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Financing Long-term Care for Older People in England

Raphael Wittenberg and Juliette Malley, PSSRU, LSE Health and Social Care

Abstract

During a decade of debate on how best to fund long-term care, British analysts have focused more on policy developments in other countries than ever before. Discussing criteria for appraising options, the paper argues that the objectives of the financing system must be considered in the light of the objectives for the long-term care system as a whole. The types of funding mechanisms discussed are private insurance, including private/public partnerships, tax-funded and social insurance models. The differences between tax-funded and social insurance models are discussed. Social insurance with hypothecation of funds is no longer part of the current debate, which now focuses on the three types of options whose properties are described in the paper: free personal care (adopted in Scotland), the retention of means-tested arrangements in some form, and a partnership model as recommended in the Wanless report. The paper agrees with the Wanless report that all three have strengths and weaknesses. Decision-makers have a window of opportunity to make reforms before the baby-boomers reach late old age.

Introduction

The recent report (Wanless *et al.*, 2006) has re-kindled the debate about the financing of long-term care in England. The debate started to smoulder before the establishment of the Royal Commission on Long Term Care (Royal Commission, 1999) and much more visibly since the publication of its report and of the Government response (Secretary of State for Health, 2000). The key issue has been who is eligible for what publicly funded care and with what user contributions if any. Underlying the debate are concerns both about the future affordability of long-term care and about the fairness of the current funding system. The debate has sharpened the criteria for the evaluation of funding systems and mobilised evidence about a wider range of policy options.

The Royal Commission's key recommendation was that the nursing and personal care components of the fees of care homes and home-based personal care should be met by the state, without a means test, and financed out of general taxation (Royal Commission, 1999). Means-testing would remain for the accommodation and ordinary living costs ('hotel' costs) covered by residential fees and for help with domestic tasks. The Government accepted many of the Royal Commission's recommendations but only removed the means test for nursing care in nursing homes (Secretary of State for Health, 2000). Similar decisions were adopted by the National Assembly for Wales and the Northern Ireland Assembly. The Scottish Executive, however, decided that it would make personal care free of charge as well (Care Development Group, 2001).

The debate on how best to fund long-term care has continued. The Joseph Rowntree Foundation (JRF) has suggested a number of ways in which the funding system could be improved (JRF, 2006; Hirsch, 2005) and the Wanless Social Care Review has proposed a partnership arrangement (Wanless *et al.*, 2006). The JRF and Wanless proposals are both based on analyses of long-term care systems internationally (Glendinning *et al.,* 2004; Poole, 2006), with an awareness that "other countries have taken major steps to secure sustainable and stable funding systems" (JRF, 2006, p.2). British analysts have become more interested in policy developments in other countries than ever before.

Criteria for Appraising Options

The purpose of long-term care provision is to promote the welfare of users and carers, including outcomes such as improved health, improved quality of life, making a positive contribution, exercise of choice and control, freedom from discrimination or harassment, economic well-being, personal dignity (Department of Health, 2005; 2006). These are broad well-being goals, which can be regarded as outcomes-based objectives for the Welfare State more generally. Financing long-term care needs to seen the context of wider developments in the Welfare State, particularly family policies, as so much care is provided by unpaid carers, health care policies and pensions policies.

The function of financing mechanisms is to contribute to the achievement of policy goals using the means and accepting the constraints prescribed by policy. The objectives of the financing system need, therefore, to be considered in the context of the objectives of the whole long-term care system. The overall system covers ways in which revenues are raised to fund care and ways in which those revenues are allocated to service users. The former include the balance between private and public sources of funding and between different public sources of funding. The latter include eligibility criteria, patterns of care and the balance between cash and care. Although this paper concentrates on the former set of issues, issues concerning revenue raising cannot be divorced from issues concerning allocation of resources.

Glendinning *et al.* (2004) proposed four criteria for assessing long-term care financing systems: equity; promotion of

dignity, choice and independence; efficiency and effectiveness; economic and political sustainability. The Wanless Review (Wanless *et al.*, 2006, p.11) used six similar criteria: fairness; economic efficiency; choice; physical resource development; clarity; sustainability/acceptability.

Efficiency and effectiveness are key criteria in economic analyses. Effectiveness refers to the achievement of a policy's stated objectives. Efficiency may be regarded as the achievement of maximum output, in terms of quantity and quality, for a given level of expenditure. In the context of long-term care, it is not ultimately service outputs that are valued but outcomes for users and carers. Achieving efficiency may, however, in practice be impeded by unsatisfactory incentives. For example, fragmented funding streams generate incentives and opportunities for cost-shifting agencies: where the costs of care are shared between agencies, the agency responsible for assessing care needs may not appreciate the true resource costs of different types of care.

Another key criterion has been equity or fairness. Equity is affected both by the ways that revenues are raised and how those resources are allocated. Equity considerations include equity of access; equity in level and mix of services relative to needs; and equity of outcomes. In the context of long-term care a key concern is horizontal equity – the provision of equal care for equal needs (Glendinning, 2004). The issue of what constitutes equity is clearly normative. Generalised perceptions of fairness may influence political judgements about balancing criteria as indicators of degrees of inequity of different kinds.

Independence, dignity and choice have been increasingly highlighted as objectives of community care policy generally (RCLTC, 1999) In the context of evaluating approaches to funding, key concerns may be to ensure that arrangements do not unduly limit older people's choice of care; distort preferences through unsatisfactory incentives; or create stigma or social exclusion.

Affordability and sustainability are important criteria and are also increasingly stated explicitly as evaluation criteria (e.g. House of Commons Health Committee, 1996). As there is much uncertainty about future demand for long-term care, and the resources required to meet that demand, funding arrangements need to be flexible and include effective cost control mechanisms. Political sustainability and acceptability is also important.

Funding mechanisms: private

Long-term care for most older people in England is provided or so supported by informal carers as to be in effect financed by them. They carry costs in terms of lost remuneration for employment opportunities foregone; leisure time foregone; direct care-related costs; psychic and health-related costs; and welfare costs of attention diverted from other family responsibilities. In respect of formal care services, costs may be incurred through user charges for publicly subsidised care; direct private purchase of services; and, possibly, premiums for private long-term care insurance.

Older people with the resources to do so could fund long-term care from their income and/or savings (including the value of their home). If necessary they could release resources invested in their home through equity release schemes (JRF, 2006). The use of savings does not, however, seem efficient. Since not everyone will need long term care, it is not necessary for everyone to save sufficient to meet the average cost of care, let alone the maximum likely life-time cost. Risk pooling through insurance seems more efficient than saving for long-term care needs. Moreover, it would also redistribute from those with lesser to those with greater care needs.

Private insurance is not, however, always feasible (Barr, 1993). Insurance for long-term care faces serious problems of market failure. These include problems about adverse selection, uncertainty concerning future risks, insurance-induced demand, and potential changes in dependency rates across the population. There are also difficulties about consumer knowledge and affordability (Glennerster, 1997; Wiener *et al.*, 1994). Pricing of long-term care insurance seems to be especially problematic. A key reason is that there is neither past experience of claims nor quality UK data with which to estimate the size of the lifetime risks involved. Measures to counteract these problems – for example, through exclusions, limitations, co-payments and higher premiums – tend to reduce the affordability and/or attractiveness of policies.

The attractiveness and affordability of long-term care insurance constitutes a significant problem. Only a minority of the population could reasonably afford long-term care insurance unless purchased early in life (or possibly through home equity release). Yet early in life people have other priorities and may be poorly informed about the risk of long term care and about the arrangements for public funding of long term care. Private long term care insurance, voluntarily purchased, therefore seems most unlikely to become widespread in England, as the Wanless review acknowledged (Wanless *et al.*, 2006, p.287). The recent exit of all but one provider from the long-term care insurance market in the UK lends weight to this view.

In principle, public support for private insurance could address some of these problems. Tax concessions or subsidies could reduce the cost to enrolees of insurance premiums, although the impact on demand for insurance would be uncertain. The public sector could reduce the cost of private long term care insurance by effectively taking part of the risk. Such partnership schemes which have been introduced by some US states have this effect. Those who purchase private insurance offering benefits of a specified minimum amount are treated more favourably under a means test, should they later exhaust their insurance benefits and seek public funding for their care. Such policies

could have lower premiums than policies with unlimited cover, because the public sector takes part of the risk. Nevertheless, the uptake of partnership policies in the USA has proved low.

Finally, the public sector could intervene to the extent of making long term care insurance compulsory. This could reduce adverse selection and other informational problems and improve affordability. Such an arrangement would, however, be regressive in comparison with social insurance: while payments for social insurance tend to be based on earnings or other forms of income, premiums for private insurance are based on individual risk, not income. The public sector could in principle address such distributional concerns by subsiding premiums on a means tested basis. This would, however, raise the issue of whether a compulsory, subsidised private sector insurance system would be preferable to a public sector system.

Funding mechanisms: public

The primary rationale for a public sector scheme is that it would allow both efficiency (through risk pooling) and equity (through redistribution) objectives to be achieved (Glendinning, 2004). A public sector scheme could range from a safety net with a substantial means test as in the UK and USA to a universal scheme for the whole population as in Germany and Japan. The main sources of public funding for long-term care are general taxation, as in the UK, Australia and Scandinavian countries; social insurance as in Germany and Netherlands; or a combination of both, as in Japan.

The difference between a tax-funded scheme and a social insurance scheme does not lie in insurance, since a tax-funded scheme also involves risk-pooling, but in the following features:

- hypothecation of revenues, that is contributions that are dedicated to long-term care;
- a link between contributions and benefits, but the link may be weak where there are credits for spells of unemployment, etc.;
- national, enforceable eligibility criteria;
- absence of a means-test but insurance can incorporate non-means-tested co-payments and deductibles.

Hypothecation has been advocated (JRF, 1996) as a means of ensuring that a specified level of resources is guaranteed for a specified purpose. Hypothecated funds for long-term care, such as in Germany, would mean that these resources would no longer compete directly with funding for other NHS or local authority services. Hypothecation has also been advocated as a means to raise more revenue for an important or popular purpose: it might be more acceptable to the public than an increase in general taxation, but this seems uncertain. Hypothecation is not without drawbacks. One problem is that the revenues raised through contributions based on earnings in any year would be affected by the economic cycle. Supplementation from general tax revenues or borrowing might be needed in some years.

A social insurance approach with hypothecated funding has, however, ceased to be part of the current debate. The debate now centres around three options (Wanless *et al.*, 2006):

- introduction of free personal care, on the lines of Scotland, under which there is no means-test for care costs;
- retention of the current means-tested arrangements, possibly with reforms such as those recommended by the JRF and/or with limit liability, such as a limit to the number of years for which the users are required to fund their care;
- implementation of the Wanless recommendation for a partnership funding scheme, as described below.

Bell and Bowes (2005) have reviewed the introduction of free personal care in Scotland. The Scottish system involves non-means-tested personal care at home and a flat rate non-means-tested contribution to nursing and personal care costs in care homes but not to 'hotel costs'. They found that the main beneficiaries have been people with dementia and people with modest means. Free personal care has not been accompanied by a major shift from informal to formal care. It has, however, proved more costly than expected and the costs are set to rise because of demographic pressures and rising home ownership.

Hancock *et al.* (2005) estimated that the introduction of free personal care throughout the UK would cost between £1.3 billion and £1.8 billion in additional public expenditure for 2002 and would take public expenditure to between 2.15% and 2.40% of GDP in 2051 or more if there were an impact on demand for care. Free personal care would benefit home-owners more than non-owners and would benefit older people in the higher quintiles of the income distribution. If financed by an increase in the higher rate of income tax, however, the net gain would be greatest for the middle income quintile of the whole population and top income quintile would be net losers.

There are a variety of ways in which the current means tested system could be reformed. These include:

- amending the capital limits by raising them, abolishing the upper limit above which service users are ineligible for any public (as in pension credit) or disregarding housing assets completely;
- increasing the personal expenses allowance for those in residential care and/or relaxing the treatment of income for those receiving home care;
- limiting liability to fund care privately by setting a life-time limit to private payments defined in terms of years of payment or total private outlay.

Hancock *et al.* (2006) found that such options for reforming

the means-test would each cost between £250 million and £1,000 million in 2002 in additional public expenditure and would take public expenditure on long-term care for older people to around 2.25% of GDP in 2051 rather than to 1.95% under the current funding system. These options mostly favour home owners and higher income groups, with the exception of raising the personal expenses allowance. Hancock *et al*. (2006) also considered a limited liability model with a lifetime maximum payment of £100,000 for residential care. The beneficiaries from this option would mostly be home owners with gains concentrated in the highest income group; the cost would be around £250 million.

The Wanless review favoured a partnership arrangement 'characterised by combining a publicly funded entitlement to a guaranteed level of care, with a variable component made up of contributions from individuals matched at a given rate by contributions from the state' (Wanless *et al*., p.278). Wanless proposed that the publicly funded entitlement should be two-thirds of the benchmark level of care. Users could choose whether they wanted the remaining third, with the costs being met half by the user and half by the state. The benchmark level of care is the level that is cost-effective given a cost-effectiveness threshold of £20,000 per ADLAY (that is 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). A partnership arrangement on these lines would require an increase in public expenditure of some £3.5 billion.

The Wanless report compares a partnership arrangement with free personal care or a means-tested system as follows:

- the partnership model is efficient: it produces the highest ratio of outcomes (ADLAYs) to costs of the three funding systems (p.270);
- it has strengths and weaknesses in regard to equity and fairness: 'for the guaranteed element, support is based entirely on need and not ability to pay, but the converse is largely the case for the matched element. . .' (p.269);
- it scores well on choice, as individuals will be able to choose the level of care they receive above the guaranteed level, albeit subject to co-payment;
- it scores as well as free personal care on dignity as no means-testing would be required within the care system;
- it is not a strong as a means-tested system on economic sustainability, but if necessary 'the guaranteed entitlement can be scaled back to reduce costs. . . or the matching contribution can be reduced' (p.271); and more options for dealing with sustainability could be added.

Conclusion

The debate about how best to finance long-term care for older people in England continues. The recent Wanless report and JRF report have highlighted a choice between three broad approaches for change: free personal care, reform of the current means-tested system or partnership arrangement. As Wanless concluded, 'all have strengths and all have weaknesses' (p.284). Policy-makers have a window of opportunity to consider these approaches before demographic pressures accelerate when the baby-boom cohorts reach late old age. Decisions will need to reflect the chosen balance between the different criteria for appraising options. They will also need to be consistent with developments in other areas of public policy such as health care and pensions.

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Correspondence
Raphael Wittenberg
PSSRU
LSE Health and Social Care
London School of Economics
Houghton Street
London WC2A 2AE
Email: r.wittenberg@lse.ac.uk