CARING CHOICES

Who will pay for long-term care?

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Overview

Some choices about paying for care are simple. Others are highly complex. The Caring Choices events have produced a remarkably consistent pattern of opinion about the simple choices. But the design of more detailed features of a funding system has provoked a multiplicity of views, and considerable division of opinion.

At this fourth Caring Choices day in Leeds, views on the basic questions followed a familiar pattern. Almost nobody thought the present system of paying for care is adequate. Nine in ten participants thought the cost of care is very likely to rise (and the rest agreed that this was 'possible'). Most believed the government needed to play a key role in providing the necessary extra resources; almost nobody thought the state should stay out of paying for care. As at previous events, a majority felt that the government should not be paying for everything, with 'co-payments' from individuals and families playing a role – but a significant minority thought that all personal care should be provided free of charge. There was widespread agreement that the quality of care should be improved, and a strong accord that unpaid carers are undervalued and need to be better supported.

However, discussions around the design of a new system revealed a wide mix of opinion. The two aspects that caused greatest controversy were the position of personal care in the support system and the role of publicly supported partnerships to unlock private money.

Many participants supported the idea of channelling public support into a universal entitlement to personal care, potentially with a private co-payment. But there were differences in views about how costs can be shared, and considerable debate about what kind of care should be supported. Some participants were nervous of a system prioritising personal care over other care needs such as preventive services and services that improve quality of life. 'Why distort resources towards personal care costs?' they asked.

Many liked the idea of public–private partnerships to help unlock money for care, but others in Leeds feared that doing so would favour already well-off people unreasonably. Another cause of anxiety in this part of the debate related to mistrust of financial institutions, alongside uncertainty about whether the public sector can deliver believable guarantees.

Both these points seemed to suggest a need for flexibility, under which a basic guarantee from the state could be used in different ways by different people. In this sense, the Scottish system of focusing support on personal care packages may not necessarily be the best model; there was interest in exploring other countries' models where a wider range of options may be available, particularly those where standardised needs-based assessments are the rationale for distribution of resources.

Discussions were focused around three broad issues:

- Who should pay for personal care?
- How do we encourage people to contribute to care costs?
- How do we support the provision of informal care?

Who should pay for personal care?

Participants were asked to consider various ways of paying for personal care, including the 'partnership' model recommended by the Wanless report, and a system that pays for a certain amount of personal care without a user charge such as the one operating in Scotland. A number of people at this event objected to being given a limited range of options, but overall the mood was favourable to the notion of co-payments. Voting at a plenary session was two to one in favour of co-payment over 'free' care, while three-quarters of participants filling out a 'points of view' survey said at a more general level that care should be a shared responsibility between the state and individual/families, compared to a quarter thinking it should just be the state. These views are broadly in line with those given at previous events.

Interestingly, the balance of views was broadly similar among the different groups taking part in the event, including the large minority (about 40 per cent of participants) who identified themselves as older people and their carers. However, support for co-payment was particularly high among service providers.

Discussions suggested that these views were informed by a combination of pragmatism and ideology. It was accepted that with tight constraints on public spending, the government is not going to pay for everything. But in addition, a number of participants, both in group discussion and in the final panel, argued that co-payment gives people 'more of a stake' in the system and helps them feel more in control. It can help promote choice not just over the type but also the quantity and quality of care that they receive, insofar as individuals can find ways of buying extra amounts of care using their own resources. One participant also suggested that 'many older people would be happy to pay a contribution, so that they feel that they are not a burden'.

However, a number of opponents of co-payments argued forcefully, from a principled standpoint, that charging is wrong. Social care, they argued, is a human right that should be provided free of charge like health care. A number of participants were particularly worried that having a private element would restrict access to proper quality care to those most able to pay for it. One suggestion was that a cash limit on charges (eg, £30 a week) would be more just than a percentage contribution. However, the worry that too much would fall on private shoulders was exacerbated by the suspicion that the government contribution would be set at a lower level than that proposed by Wanless, that quality would be neglected, and that entitlements would not be properly uprated with rising costs over time.

'People are prepared to pay for better care as long as there is the quality', said one person who favoured a 70:30 split between government and individuals, although others doubted whether such a system would deliver the quality required.

A different concern, which recurred throughout the day, was that personal care was not the place to concentrate government resources. Indeed, one care advocate went so far as to suggest that fully free personal care is undesirable precisely because it would shift money away from prevention and practical help. As in previous events, there was some discussion about whether prevention represents good value for money – and broad consensus that it does, even though nobody has been able to prove unequivocally that it will save money by reducing the need for personal care later on.

A further point that emerged at this event was the issue of how co-payments would be managed. Trust in government in dealings with personal entitlements is low after the difficulties with tax credits. A universal co-payment system with a single assessment would have the advantage of not requiring means-testing. A key element in its success would be to provide the simplicity that allows people to plan their finances sensibly.

How do we encourage people to contribute to care costs?

In this Caring Choices event, three examples of mechanisms to help people contribute to the cost of their care were put before delegates. These were public help with, respectively, private insurance products, equity release and continuing care communities. Each of these commanded a certain level of support, with continuing care communities getting the highest level. Yet a substantial minority of participants thought that none of these mechanisms merited public support, and each individual proposal attracted a mixture of enthusiasm and criticism.

The most common overall reservation was that these were seen as supporting middle-class people who could afford to invest some of their own money, and that this should not be a priority for government spending. That criticism applies least to equity release, since many people on low incomes now have housing assets, yet even here it was suggested that it would be unfair to provide public help to home owners what would not be available to those who are not lucky enough to own a home.

While a majority of participants saw support for private care insurance as an appropriate use of public money, the strongest negative views also emerged with regard to this option. Many people did not have the trust in private financial institutions to be confident that this could be provided on a fair basis. Public support might in principle help, but this could cause all sorts of grey areas and 'buck-passing' about who was responsible for what. A real problem with trying to argue that private insurance should be subsidised by the public purse is that this commonly causes people to ask 'well, why not just have social insurance instead?'

On the other hand, there were many positive reactions to the idea of buying into continuing care communities. Among attractions that generated considerable enthusiasm for this option were the ability to pool the risk of high care cost of one's neighbours; the stable guarantee of quality care for a fixed cost and the facility of accessing a range of services on site without living permanently in a care home. Nevertheless, a number of participants felt that this option was designed mainly for the better off. Public enthusiasm for government subsidies for schemes may depend on them being made accessible to people on modest incomes and assets. However, in this audience, nearly three-quarters thought they were worthy of public support.

Equity release continues to be something that divides audiences of this type. Some see it as a commonsense way of accessing huge resources locked up in one's home. Others see it as a 'con', either by the institutions that provide it or by governments wanting to save money. This audience was no exception, and was more or less split down the middle on whether it was worthy of government support. Some people saw it as an ideal way of meeting lower-level needs in particular: 'An extra £3000 a year would go a very long way'. Others saw it as a trap and a denial of what they had worked for, by eating up an inheritance: 'I had £100 left to me by my mother in law, and I would like to do better by my family.' As at previous Caring Choices events, emotions about equity release were closely tied into feelings about inheritance, which some felt was fundamental and others thought less important. One contributor even suggested that inheritance is an 'out-of-date idea' at a time when assets are needed to help pay for the costs of old age.

How do we support the provision of informal care?

Improved support for informal care raises less political controversy about 'who pays' than issues around expensive care services, but it certainly generated some of the most heartfelt emotions on this occasion. In response to a question about what we can do to help carers under intense daily pressures with nobody to turn to, a commentator on the final panel neatly summed up the mood of the audience: 'We rely on carers, but we do not protect them from the desperate situations that you describe.'

The audience supported a range of measures to help carers, from better information and advice to financial support or formal recognition of their contribution, skills and experience. The issue of getting clear information, advice and advocacy was highlighted as a particular concern for black and minority ethnic (BME) elders.

Participants emphasised that carers' needs vary, and it was a matter more than anything of raising awareness of these needs, for example, with employers, where they tend to be hidden.

But one particular form of support requiring improvement came out ahead of all the others on this occasion, both in discussion and in voting. This was respite care. The inability of carers to escape from their daily challenges is perhaps the biggest burden that they carry. The plea was not just for more such services but for ensuring that they meet the real needs of carers and of cared-for older people. This means having back-up available in emergencies, as well as giving users flexibility in the ways in which such services are used rather than respite being dictated according to the convenience of the service.

At the heart of solutions in this area is not money but attitudes. Both employers and the general public need to become more aware of the pressure on carers. And in promoting greater understanding, it is important to take diversity into account. One participant called for a greater understanding of the cultural and spiritual needs of BME elders and carers.

While there is no single magic solution for meeting the needs of carers, participants emphasised that we have to start finding imaginative new ways of improving things. Some users expressed enthusiasm about the prospects for telecare, and showed a high-level awareness of technological progress in this area. Other participants

suggested that we need to strengthen mutual community support, perhaps through a revival of ideas such as time banks. Such mutual support would reduce the extent to which carers need to rely on government action, but does not let the government off the hook in giving carers much greater recognition. Among interesting ideas for new services that the government might help fund was a '999 emergency service for carers'.

More spending by government on this kind of service were seen as excellent value for money: anything that can make informal caring more sustainable for families under pressure, whose own health may be under threat, could save huge amounts in the long term.