Past caring?

Widening the debate on funding long term care

AN ILC-UK THINK-PIECE

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About the author

Craig Berry is a Senior Researcher at ILC-UK. He worked previously as a Policy Advisor on Older People and State Pensions at HM Treasury, and completed his PhD at the University of Sheffield in 2008.

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Foreword

Since 2008, the International Longevity Centre-UK has been at the forefront of the debate on funding long term care. Our proposals for a National Care Fund and the development of a private market in care insurance were extremely influential on the development of policy under the previous government.

Yet there remains a lack of consensus on how to proceed, and the debate has evolved significantly more recently. Given the financial crash and subsequent fiscal crisis, the formation of the coalition government, and the appointment of the Dilnot Commission, there is a need to revisit our proposals. One possibility is that a system of voluntary insurance, with a foundation of taxpayer-funded minimum support, will be introduced, replacing the social insurance model proposed originally by ILC-UK.

I hope that the Dilnot settlement forms the basis of a fair and sustainable solution to the care funding crisis. However, the political and fiscal conditions are not the only things to have changed since 2008. It has also become increasingly apparent that care funding is an issue that cannot be discussed in isolation. As such, this think-piece by ILC-UK Senior Researcher Craig Berry will place the funding of long term care in a much broader context in terms of policy options and socio-economic trends.

Among the issues and developments that must be considered before a sustainable solution can be found are: the role of unpaid carers; the integration of health and care provision; pensions reform; the role of personal budgets and new technology in delivering care; the increasing popularity of extra care housing; the consumer marketplace for older people; and the growth and nature of the care workforce.

This paper sketches a new model which takes into account many of these issues, while exploring the private insurance market and what individuals can expect from the state. It should be read by anyone who cares about care in the UK. It will not put an end to the debate - nor is it designed to serve that purpose. But I hope it enriches the conversations we will continue to have about one of the huge challenges facing our society today.

Baroness Sally Greengross

Chief-Executive, International Longevity Centre-UK

Executive summary

The care funding debate:

- Care needs are amorphous; care provision should be seen as a 'type' of intervention.
- The current long term care system and its funding arrangements are complex, geographically variable, unsustainable, and act to disincentivise the accumulation of assets for retirement.
- The Wanless partnership model embodies a 'pot fallacy' which among other things inhibits recognition of three 'frontiers' of care delivery between health and care, formal and informal care, and care provision and a range of other services such as housing.
- The Dilnot Commission is likely to uphold a broad partnership approach, but appears to recognise the co-dependence of funding and delivery, and care and other services ï as well as the need for individuals to make greater direct contributions their own care costs.
- The Dilnot approach is broadly correct in that it moves the system towards a mixed economy of care. But a fair and sustainable care funding system will depend on a redefined and enhanced role for the state and general taxation, alongside private sources of funding.

The role of the state:

- The principle of social insurance was important to the creation of the welfare state but has become increasingly meaningless in practice.
- The long term care funding model devised originally proposed by ILC-UK offers a purer version of social insurance, but could replicate the complexity of social insurance, and would remain dependent on means-testing.
- Yet the Wanless partnership approach also upholds a problematic vision for the role of the state in funding care, by advocating direct subsidies to the wealthiest care recipients and those with the least severe care needs.
- Health and care provision should be more closely integrated in many ways, to enable operational efficiency, rational budgeting, legitimacy and a more appropriate funding stream within the mixed economy of care.
- A period of transition towards a plural funding system requires a form of the National Care Fund to be introduced, to serve those approaching retirement.
- Over the long term, a broad partnership approach to long term care funding system will enable future generations to alter the balance between public and private funding as appropriate.

Beyond the state:

- Private insurance has an extremely limited role in the current funding system, due in part to uncertainty over future funding arrangements, as well as a range of other supply-side and demand-side barriers. But it could play an important role in enabling user-centred care services within a mixed economy of care.
- Innovation in the annuities market would be necessary to establish a mass market, but it is also possible that pensions saving vehicles could be used to enable individuals to save more for care costs in later life.
- A second frontier in care delivery exists between formal care provision and a range of other services provided predominantly by the private and voluntary sectors; a future funding system must not inhibit innovations such as extra care housing.
- There is widespread public support for the continuing role of informal carers in long term care provision. Informal carers face significant difficulties, and support under the current system is inadequate.
- Formal and informal care are not functionally equivalent. The Scottish experience shows that increases in formal care provision do not lead to a reduction in informal provision. This understanding has been missing from the recent debate on long term care funding.
- To avoid inequality, a future funding system must take informal care provision into account when assessing needs, although provide higher levels of compensation and support to those informal carers substituting public sector provision.

Introduction

This think-piece addresses one of the most controversial and intractable issues in UK politics today: how to fund long term care. Its main aim is to broaden the debate with reference to a range of issues that must be taken into account before a sustainable and fair funding settlement can be reached. As such, the think-piece does not put forward a concrete set of proposals as to what the Dilnot settlement should look like. Yet it builds upon elements of various models proposed in recent years to sketch a series of ideas which could be adopted by the Commission, or incorporated at some later point as a skeletal funding system evolves in operation.

To preview the argument that will be developed in the paper: ostensibly the partnership model, a variant of which is likely to be proposed by the Dilnot Commission, offers significant opportunities for a fair and sustainable funding system for long term care, given that it could lead to the removal of means-testing, and offers an ambitious vision for the role of the state and general taxation in care funding. In these ways, it may be broadly preferable to the International Longevity Centre-UKôs (ILC-UK's) original social insurance model. But the partnership model suffers from what is termed here 'the pot fallacy'. It assumes that an individual's care needs can be quantified by estimating the cost of meeting these needs ï the goal of the funding system is therefore to fill a hypothetical pot. In reality, there is no pot, due in part to the existence of three 'frontiers' within the mixed economy of care: between care provision and health provision, between formal and informal carers, and between care and array of other services which feed into care delivery, most notably housing. The existence of these frontiers defies the notion of the pot, and it is increasingly at these frontiers where innovation in care delivery will occur, undermining any rigid funding settlement. Of course, proponents of the partnership model are cognisant of these frontiers ï and many others. The argument here is that, on balance, designing a funding system which 'brackets off' the frontiers for the sake of political consensus, organisational simplicity and to address a short term funding crisis may lead to worse care outcomes over the long term.

The think-piece argues that many aspects of care provision should be more closely integrated with health provision, paid for by the taxpayer but with scope for individuals to top up state-funded provision. This is not to wholly deny the distinction between health and care, but rather, to recognise that many care needs are as serious as the kind of problems addressed by the National Health Service (NHS), and that general taxation is the most appropriate funding stream for meeting these needs on a large scale. Crucially, however, not all care needs can be addressed in this way. Care needs are essentially amorphous; many are most appropriately met by families and communities, and the funding system should recognise this amorphousness. Many services will also be provided through innovative mechanisms such as extra care housing, funded through both public and private mechanisms. Given that many people will also seek to top up services or insure against the risk of care needs arising at a level not deemed appropriate for universal,

taxpayer-funded services, private insurance will have a significant role in the future of care funding.

Such changes will by necessity emerge piecemeal rather than perfectly formed. This is in part due to the nature of the funding dilemmas facing the care system, and public services more generally, but also because the amorphous nature of care demands a responsive and user-centred system, requiring flexibility in delivery. Of course, this does not mean that the need for urgent reform can be ignored. As such, the think-piece develops a short-term solution which builds upon aspects of ILC-UK's social insurance model, while arguing that the social insurance principle may no longer be an appropriate foundation for welfare provision, and that ultimately means-testing within the care funding system must be eliminated.

The first section outlines the existing system and the recent debate on how it should be reformed. It then looks at the role of the state in a future care funding system, before turning the role of the private sector. Of course, these two realms cannot and should not be entirely distinguished. Therefore, the second section will consider how state provision interacts with a care marketplace, as well as the nature of care as a publicly funded universal service, the integration of health and care, and how long term reform can be preceded by short term solutions. The third section will consider how the state can support private provision, as well as the role of private insurance and other private and voluntary sector services. It will also look at informal carers, who will continue to play an important role in long term care. It should be noted, the focus is on long term care for older people in England, although the think-piece will refer to working-age care recipients and systems within other UK countries where appropriate.

1. The care funding debate

Key points

- Care needs are amorphous; care provision should be seen as a 'type' of intervention.
- The current long term care system and its funding arrangements are complex, geographically variable, unsustainable, and act to disincentivise the accumulation of assets for retirement.
- The Wanless partnership model embodies a 'pot fallacy' which among other things inhibits recognition of three 'frontiers' of care delivery between health and care, formal and informal care, and care provision and a range of other services such as housing.
- The Dilnot Commission is likely to uphold a broad partnership approach, but appears to recognise the co-dependence of funding and delivery, and care and other services ï as well as the need for individuals to make greater direct contributions their own care costs.
- The Dilnot approach is broadly correct in that it moves the system towards a mixed economy of care. But a fair and sustainable care funding system will depend on a redefined and enhanced role for the state and general taxation, alongside private sources of funding.

The existing system

The range of activities that could be defined as care is probably endless, given that meeting a care need is not about delivering a certain service, but rather producing a certain outcome, by various means. Needs themselves are in many ways amorphous. Care should therefore not be thought of as an intervention, but rather a 'type' of intervention that could in practice take many forms (Kippin, 2010). This does not mean that care needs are not often severe and complex, but rather that the services required to meet these needs cannot be straightforwardly defined.

Social care lacks a distinct institutional identity, especially at the national level. This is partly derived from the amorphous nature of care interventions, but it has nevertheless contributed to several problems within existing provision. Elements of long term care for older people are provided variably by local authorities, the NHS, private providers, social security payments, and informal carers. These providers co-exist by necessity, and therefore interact in various ways, but do not represent a coherent, joined-up approach. It is rather that each has certain responsibilities that contribute to what we think of as care provision. In practice they encounter each other, but their interactions have only been rationalised *post hoc* and therefore untidily. The long term care system in the UK is extremely complex for both providers and recipients.

In addition to the lack of a joined-up approach, and endemic complexity, the third main criticism of care provision in the UK derives from the fact that services are generally designed and delivered by local authorities ï the so-called 'postcode lottery'. Local authorities differ in charges and categories of need covered.[1] In terms of charges, hourly charges for domiciliary care and support range from zero in Tower Hamlets to £19.34 in Poole. Many local authorities have no cap on the maximum that can be charged to

[1] See www.which.co.uk/money/retirement/guides/long term-care/care-funding-and-assessments/

recipients each week,[2] but maximum charges among those that do operate a cap range from £60 in Barnsley to £850 in Brighton. Prices of individual meals range from £1.40 in Derbyshire to £6.26 in Northamptonshire. In terms of need, there does exist a uniform, national system by which severity of needs is assessed. A small number of local authorities offer care to everyone with some care needs, but a larger (and growing) number only offer care to those with critical needs. The care system is also heavily reliant on informal care by friends and family (which most local authorities take into account in determining which services to provide). This leads to inequality between those that can draw upon informal care, and those that cannot ï although the support available to informal carers is almost negligible, and many with care needs do not receive support from local authorities due to the apparent availability of informal care. There is also, to some extent, inequality between those that can afford to pay for additional care services privately, and those that cannot, although many with care needs with relatively limited wealth or income are compelled to 'self-fund' their care. It should be noted here that the aspects of care provision provided by the NHS (largely 'continuing care' provided by nurses) are not marred by the postcode lottery to the same extent.

Care funding is as complex as care delivery, albeit less justifiably. NHS care is provided free at the point of need (funded by general taxation). Many older people with disabilities receive Attendance Allowance, a universal benefit (funded by general taxation) which may be used to fund local care services, although problematically assessments for eligibility are different to assessments elsewhere within the care system. Attendance Allowance is simply a cash payment; there are no restrictions on how the benefit is used. It plays an important role, alongside personal wealth and income, in funding private care services, or indeed supporting informal carers. A small number of people have private insurance products (either pre-funded or point-of-need) to cover care costs, although technically these products help to manage the contributions of individual self-funders; they are not sources of funding in themselves. Some informal carers will have access to Carer's Allowance. Support for informal carers will be discussed in more detail in the third section, but it should be noted here that Carer's Allowance does not constitute a significant source of funding for informal care provision.

For the most part, care services are funded by both individuals and taxpayers (through general local authority funds from a variety of sources) via a highly complex system operated by local authorities where individual contributions are determined by means-testing. People needing domiciliary care are required to pay full costs (for local authority services) if they have assets worth more than £23,250, excluding the value of their main home (2010/11 figures). Those with assets worth less than £23,250 may still have to pay towards the cost of their care, although contributions are subject to the Guarantee Credit rule.[3] For residential care, all housing wealth is included in the means test (unless the main home is occupied by a spouse, a relative aged over 60 or under 16, or an incapacitated

[2] Although there is a basic rule that care charges cannot reduce your remaining income to less than 1.25 times the level of Guarantee Credit. For a single person this currently gives a protected weekly income of £165.75.
[3] See footnote 2.

relative). In practice, local authorities are incentivised to recommend residential care, so that they have full access to housing wealth as a source of funding (Lloyd, 2008a). An added complication is that for both domiciliary and residential care, anybody with assets valued between £14,250 and £23,250 are assumed to have a weekly income of £1 for every £250 above £14,250 (this will impact upon the Guarantee Credit rule).[4]

Clearly, the funding system is extremely complex ï causing avoidable stress and confusion, and undermining the legitimacy of the system. Means-testing also creates very steep cliff-edges between those receiving care (including 'hotel costs') largely or wholly free of charge, and those self-funding all or most of their care. The principal reason, however, that the care funding system has been subject to such intense scrutiny in recent years is its apparent unsustainability. Increased life expectancy (which is currently out-pacing healthy life expectancy) and population ageing (which results from longevity but also the impending retirement of the baby boom cohort) will mean the number of people potentially eligible for state support will increase significantly over coming decades. Estimates of the *present* costs of long term care for older people vary considerably, depending on whether older people are disaggregated from adult social care more generally, whether 'hotel costs' are included, and how NHS investment in long term care is valued. The 2007/08 net public cost of adult social care in England was £13.34 billion. This includes those aged below 65, but also excludes expenditure on care by the NHS and the benefit system. Policy Exchange has calculated the 2008/09 expenditure, including relevant health and benefit expenditure, on older people alone as £16.7 billion (Featherstone & Whitham, 2010). Additionally, it is believed private households in England spend over £8 billion per year on care services (DH, 2011), and informal carers provide care valued at around £70 billion (or £87 billion UK-wide) (Buckner & Yeandle, 2007). Even if the present system remains in place, increasing demand (estimated at around 30-50% by 2050) and cost inflation will see costs to the state rise substantially in coming decades, perhaps doubling within 30-40 years (see Humphries et al, 2010; Lloyd, 2008a). Yet the problem of unsustainability does not apply to the state alone. For many individuals, care needs are going unmet. With increasing demand and rising longevity, this scenario is highly likely to intensify.

Funding shortages are already having an impact on care budgets ï and interacting in various ways with the underlying 'postcode lottery' problem. Consumer champions Which? have reported widespread 'rationing' by local authorities as they tighten eligibility for access to care services. While geographical variety remains, 70% of local authorities in England and Wales now provide care only for individuals deemed to have substantial or critical needs. Many councils in 2010/11 also removed their cap on weekly charges, having had a cap the previous year. Incredibly, however, three local authorities in England provide domiciliary care for free, as in Scotland.[5] Furthermore, analysis by the Kingôs Fund

[4] In Scotland, personal care services are provided for free by all local authorities. Costs of personal care should be distinguished, however, from the 'hotel costs' of care provision. People in residential care in Scotland still have to pay for their accommodation, and are subject to local variations arguably even more extreme than those in England.

[5] See www.which.co.uk/news/2011/01/home-care-charges-lottery-revealed-by-which-242460/

suggests that a £1.2 billion funding gap could open up within care budgets by 2014, as a result of the governmentôs local authority spending cuts. The government believes that efficiency savings will eliminate this gap (delivered partly by closer working between councils and the NHS), although this would require unprecedented efficiency improvements. While spending on adult social care has grown in real terms by over 5% each year since 1994, much of these increases have been absorbed by demographic changes. Indeed, spending on care for older people ï the main source of demographic pressure ï has risen by less than 3% in the last five years (see Humphries, 2011).

The story so far

After its election in 1997, the Labour government established a Royal Commission on Long Term Care, seeking to deliver on the party's promises in opposition to end the forced home sales that preceded entry into residential care for many older people. The Commission's final report, published in 1999, recommended among other things that personal care should be provided to older people free at the point of need, funded via general taxation. In 2000, the government rejected the recommendation. It was, however, accepted by the devolved administration in Scotland. Scotland therefore introduced free personal care in 2002. In line with the Commission's recommendations, 'hotel costs' associated with residential care remained the responsibility of individuals, with only those without sufficient housing wealth having their housing costs covered by the state.

In 2005, the Kingôs Fund established the Wanless Social Care Review, led by Derek Wanless, to construct a new funding model for long term care. The final report, *Securing Good Care for Older People* (2006), proposed a ópartnershipôapproach. Essentially, the state would determine a total care package (excluding hotel costs) required for each individual. The state would then provide a certain proportion of this care (Wanless suggested 66%). Individuals would be encouraged to contribute further to achieve the full package ï and the state will match in full each £1 contributed by individuals. Means-testing would not feature in the provision of the stateôs benchmark proportion, although given the likelihood that wealthier households would be far more likely to be able to contribute to their care package (and therefore receive matching contributions from the state), Wanless proposed that the poorest households would be supported in making contributions through the benefit system. In the face of mounting fiscal problems, the Wanless model was revised by the Kingôs Fund in 2010. Richard Humphries et al proposed that the proportion of the care package provided by the state should be 50%, and that individual contributions would be matched at the rate of £1 for every £2.

One of the key arguments in this paper is that funding models based on the partnership approach are uphold the fallacious notion that an individual has a given volume of care needs, which can be quantified by estimating the cost of meeting these needs. The *raison d'etre* of this model, therefore, is to fill a clearly defined ópotôwith contributions from the state and individuals in order to fully fund the cost of meeting these needs. This is not to

suggest that, in practice, individual care needs cannot be assessed in accordance with a universal assessment method, and costed reasonably accurately by providers. But to construct a funding system based on the notion of the pot is problematic ï most significantly, there seems to be no mechanism for valuing (and therefore matching) informal care as a way for individuals to contribute to the pot, nor any recognition within the funding model that individual care needs evolve over time. The amorphous nature of care defies the notion of clearly demarcated and quantifiable care needs. In other words, filling the pot (by whatever mechanisms) would not mean that all individuals have all or most of their care needs met; indeed, it may mean that some individuals receive in practice care services beyond that intended by the funding model. Of course, proponents of the partnership model are not unaware of these limitations, and accepting them may arguably be a price worth paying in the short term.

In 2008, James Lloyd of the International Longevity Centre-UK developed an alternative funding model based on the principle of social insurance. Lloyd, now Director of the Strategic Society Centre, was seconded to the Prime Ministerôs Strategy Unit shortly afterwards in order to support the Labour governmentôs delivery of a care funding settlement. Lloyd proposed a National Care Fund (NCF), backed by the state but funded for the most part by individual contributions. The NCF would fund in full a standard package of care (excluding hotel costs), as determined by the state. Individuals would join the NCF at around state pension age by agreeing to pay an enrolment fee, which would be determined by an assessment of means, and could be deferred. The average fee would be around £10,000, that is, the lifetime cost of long term care apparently required by the median individual. But fees would be capped for the wealthiest households, and the poorest households would not be required to pay an enrolment fee. Lloydôs model therefore entrenches means-testing within the long term care funding system.

In early 2010, the Labour government published the white paper *Building the National Care Service*, which broadly adopted Lloydôs model, having re-labelled it as a ócomprehensiveôapproach given that it proposed a National Care Service (NCS) which would provide a standard care package in full (excluding hotel costs). Individuals would have to pay to realise their entitlement to NCS provision, but unlike the partnership and private insurance-based models, would then be unburdened in full from the cost of meeting their future care needs. It is on this basis that the Labour government argued that the comprehensive approach was the most progressive option available. However, the extent to which the proposals would have led to a redistributive funding system depend on the design and level of fees payable by individuals; the Labour government delayed a decision on precise funding arrangements. In theory, a partnership model could be equally or even more redistributive than the so-called comprehensive approach, depending on the benchmark proportion of the care package funded directly through general taxation, and how the tax revenue is raised. Lloydôs social insurance model would have probably produced more redistributive outcomes than the partnership approach due to the extent of means-testing in the determination of enrolment fees, yet the Labour government did not

adjudicate on this issue.

It will be argued in this paper that a series of 'frontiers' within care delivery would to some extent undermine the efficacy of both the partnership and social insurance models. In practice, as under the current system, both models would by necessity accommodate these frontiers. But if we recognise why the frontiers exist, and their immutability, it may be possible instead to utilise them within a less prescriptive 'mixed economy' approach to funding long term care. As suggested above, the most obvious frontier lies between formal and informal care. Additionally, there is a frontier between care and a range of other services provided by the public, private and voluntary sectors, most notably housing: the models discussed here all exclude hotel costs from their proposals. In reality, housing provision for care recipients is a key element of care provision which cannot be bracketed off. There is no easy way to address the interaction between care and housing ï which is precisely why we cannot base funding models for long term care on the notion that housing, among other things, can be dealt with through other financing mechanisms. A further problem afflicting both the partnership and social insurance models is that they take individuals as the main referent of the funding system. However, the fact that individuals are the recipients of care services does not mean that the individual is in fact the appropriate referent for the funding system. In common with the current funding system, the various models may encounter difficulties in disaggregating individual wealth and income from that of their family or household.

Dilnot and beyond

Shortly after taking office, the coalition government asked Andrew Dilnot, alongside Dame Jo Williams and Lord Norman Warner, to determine a new funding settlement.[6] The criteria that the Dilnot model must meet, developed in conjunction with the government, are: sustainable and resilient (both fiscally and demographically), fairness, choice, value for money, and ease of use and understanding. The Commission itself has defined the overarching principles of its work as maximising the well-being (including dignity and community participation) of individuals and families, and recognising and valuing the contributions of all parties (including informal carers) involved in care and support.

There are signs, therefore, that the Dilnot Commission will overcome the pot fallacy in taking a much broader view of what care is, and how it can be delivered. For instance, whereas the partnership and social insurance approaches are designed to be neutral regarding delivery issues, the Dilnot Commission are seeking a settlement that is ócompatibleôwith emerging innovations in care delivery, such as personalisation and preventative care, and other services such as housing. This does not mean, of course, that the Dilnot settlement will achieve a fair and sustainable funding settlement, even judged on its own terms. There are enormous issues to be tackled, such as the role of means-testing and the tension between short and long term reform, for which there are no easy solutions.

[6] The Dilnot Commission will look at funding care services for working-age people as well as older people.

The indications are that the Commission is likely to propose a system whereby the state agrees to fund a basic level of care provision through general taxation, and individuals supplement provision through private insurance products. There are uncertainties around the nature of the stateôs financial contribution: will the state cover a certain proportion of individualsôcare needs, or will it instead stipulate the range of services that it will provide free at the point of need, signalling to those in need of additional services that some form of self-funding is required? The former has been termed a ôhybrid approachô by Policy Exchange, given that it combines a partnership approach (minus the matching contributions) to proposals originally made by the Conservative Party for a system based on voluntary insurance (Featherstone & Whitham, 2010). Any attempt by the state to define the proportion of a care package that it will fund is problematic, given the amorphous nature of care needs and the existence of various frontiers between formal care and other aspects of care delivery. Indeed, even the social insurance model, which would theoretically fund the care package in full, would confront dilemmas around precisely hat qualifies as a care service.

What is required, therefore, is a mixed economy in care provision. The state would establish the range of services it will provide for free at the point of need, funded by general taxation, and the circumstances within which it will provide them. A range of other mechanisms would be nurtured (many are of course already in existence) to provide an array of supplementary or alternative services, funded by various financial and non-financial mechanisms, many of which the state would support. The remainder of this think-piece will add detail to this vision by discussing the role of the state and private sector, and the care workforce that will ultimately deliver it. At the level of principle, the vision resembles the partnership approach in that it envisages multiple sources of funding ï but it does so not simply for reasons of fiscal sustainability, but rather because the nature of care demands a pluralistic approach to funding. It also seeks to achieve similar outcomes to the social insurance model in that it redefines and augments the role of the state in funding care and bearing risk.

2. The role of the state

Key points

- The principle of social insurance was important to the creation of the welfare state but has become increasingly meaningless in practice.
- The long term care funding model devised originally proposed by ILC-UK offers a purer version of social insurance, but would replicate the complexity of social insurance and remain heavily dependent on means-testing.
- Yet the Wanless partnership approach also upholds a problematic vision for the role of the state in funding care, by advocating direct subsidies to the wealthiest care recipients and those with the least severe care needs.
- Health and care provision should be more closely integrated in many ways, to enable operational efficiency, rational budgeting, legitimacy and a more appropriate funding stream within the mixed economy of care.
- A period of transition towards a plural funding system requires a voluntary form of the National Care Fund to be introduced, to serve those approaching retirement.
- Over the long term, a broad partnership approach to long term care funding system will enable future generations to alter the balance between public and private funding as appropriate.

Beveridge and beyond

The principle of social insurance has influenced the development of the UK welfare state profoundly. William Beveridge's vision for a welfare state which eliminated the five 'giant evils' of want, disease, squalor, ignorance and idleness envisaged that citizens would make payments to insure themselves and their children against the risk of befalling one of these evils. The state was best place to pool this risk, and as such the National Insurance (NI) system was born. Yet NI has long ceased to play a meaningful role in the organisation of the welfare state. It remains an important source of revenue for the state, and occasionally governments will cite the principle of social insurance to justify raising NI rates (as the Labour government did when it raised NI rates to pay for increased health expenditure in 2002)[7] but the funds raised through National Insurance contributions (NICs) are not hypothecated within national accounts. One of the few places where NICs continue to play a meaningful role in the provision of welfare and social security in the UK is in determining eligibility for the state pension ï benefit entitlement is determined by the number of years that individuals have paid NICs. However, the previous government's decision to reduce the number of qualifying NICs years needed for a full basic state pension, and the current government's plans to move towards a residency-based entitlement for state pensions, renders the principle increasingly hollow. David Martin's persuasive pamphlet for the Centre for Policy Studies, *Abolish NICs* (2010), shows that in operation NI is unnecessarily complex and more regressive than income tax. Most welfare and social security expenditure, by necessity, is not based on social insurance, and indeed non-contributory benefits are often more generous than contributory benefits. It is arguable that the principle of social insurance has been replaced almost entirely by an expansive

[7] See webarchive.nationalarchives.gov.uk/20100407010852/http://www.hm-treasury.gov.uk/bud_bud02_index.htm

version of citizenship, that is, the notion that by virtue of citizenship alone individuals are entitled to certain forms of support and security from the state, assuming they uphold their responsibilities as members of society.

Of course, ILC-UK's original proposals for long term care funding were based on the notion of social insurance. This think-piece is not the place to discuss the merit, or otherwise, of the social insurance principle. Yet while the Lloyd model arguably offers a purer version of social insurance, and its funding mechanism would theoretically remain discrete within national accounts, there are some commonalities between Lloyd's model and NI. Firstly, complexity at the point at which individuals make their insurance contribution. The NCF payment principle is itself straightforward: individuals are given notice of their enrolment fee, they decide how to pay the fee, and as a result they do not need to worry about care costs for the rest of their life. But the actual transaction could be fairly complex; many would choose, often by necessity, to pay the fee in stages, and by various means. Secondly, whichever payment method is chosen, the NCF essentially introduces another form of taxation ï it may be fairer that existing NI taxation in many ways, but there are inevitably significant political barriers in this regard. As such, if the NCF or an equivalent were introduced, we could expect the charge to persist from the public that they thought social care was a public service already provided for free at the point of need, funded by income tax and/or NICs.

The social insurance system has also been criticised for seeking to entrench means-testing within the care funding system. Of course, the partnership approach would be similarly dependent on means-testing, albeit through the benefits system rather than the care system directly ï but nevertheless it is understandable that the current government is seeking to minimise means-testing within care provision. Clearly, in an unequal society, individuals cannot be expected to make equivalent insurance contributions to ensure access to public services, even where the entitlements that result from contributions are identical. This is why the NCF would charge different enrolment fees to individuals with different levels of wealth and income.[8] In a supplementary paper following the outline of his model, Lloyd (2008c) presents powerful arguments in favour of means-testing. In terms of means-testing, Lloyd's original model is superior to the current system in that every individual is charged an appropriate, one-off fee, avoided the very steep cliff-edge and administrative complexity that exists in the current system of means-testing. Against the charge that means-testing punishes those that have used their income to save over their lifecourse to meet their cost of living in retirement, Lloyd argues that the wealth of many retirees is 'unearned' as it is derived from house price inflation.[9] Lloyd also shows that mechanisms can be designed to prevent 'deliberate deprivation' whereby individuals seek artificially reduce their wealth or income in order to reduce their enrolment fee. However, the system would inevitably punish some people for frugal lifestyles, or labour market

[8] Arguably therefore the NCF would be more progressive than the general NI system, which generally takes the same proportion of income from all individuals.
[9] Lloyd may be correct in making this point regarding housing wealth. But the exclusion of hotel costs from the NCF makes this reliance on housing wealth problematic, in both theory and practice.

success ï that is, people whose wealth in later life cannot be defined as unearned ï which is precisely why Lloyd's model would introduce a cap on enrolment fees, and encompass some state support for private insurance products. The system would certainly maintain the *perception* of unfairness that seems to accompany any aspect of means-testing in welfare provision, therefore undermining its legitimacy. If means-tested contributions to funding care are appropriate, it is hard to imagine any funding mechanism overcoming the criticism that income tax is a far more appropriate mechanism for garnering progressive contributions from individuals (although this charge would be unfair in many regards, as will be discussed below).

The partnership approach seemingly favoured by the Commission does not rely on the notion of social insurance, but nevertheless also upholds a problematic vision of the stateôs contribution to long term care funding in some ways. Ultimately, the matching contributions that the state will make to incentivise individuals to contribute to their own care costs would represent subsidies for wealthier individuals and households more able to contribute to their own care (despite the possibility, as Lloyd recognises, that their wealth may be at least partly óunearnedô). The rationale for these subsidies is largely sound: the partnership approach is seeking to remove the steep cliff-edge present in funding systems based on means-testing. Those that have accumulated some wealth to cover their cost of wealth should be rewarded for having done so ï if they are only entitled to the same level of state support as those without private wealth, the care funding system would introduce (or maintain) a savings disincentive.[10] Lloyd (2008b) argues, however, that the partnership approach therefore allows ópernicious redistributionôbecause those most able to pay for care services privately are given more support from the state than those that are not ï despite the fact that state support would be funded by general taxation. Ironically, in this regard the partnership approach resembles the current practice of NI more than Lloydôs social insurance model. Of course, all welfare expenditure to some extent funds services for people that may be able to pay for them anyway in the absence of the state ï this may indeed be necessary to maintain the sense of social solidarity through which all welfare and social security provision is legitimised. Furthermore, although public services are by nature redistributive, we cannot expect any funding model for long term care to correct the wealth and income inequalities that exist within societies more generally. However, there are certainly questions around whether the matching contributions envisaged by the Wanless model represent an appropriate use of public funds.

A further problem regarding the partnership approachôs vision for the state in funding long term care relates to the pot fallacy, discussed in the previous section. The amorphous nature of care needs means that the proportion of care costs covered directly by the state would mean different things to different people. At the most basic level, severity of care needs will differ between individuals (as well as evolving over time). If one person has only very moderate care needs, requiring a package of low-level intervention, would the state

[10] In fact, as noted above, the partnership model would in practice be dependent on means-testing, as the poorest households would be supported through the benefit system to make their individual contributions (although this will of course be a feature on any funding system, at least in the short term).

still fund 66% (or 50%) of their care package, despite the fact that the costs associated with the remaining proportion could be fairly minimal? Would the same state-funded proportion apply to someone requiring a substantial level of care, even though the cost of the remaining self-funded proportion could be extremely high? Moreover, where would preventative care sit within the individual care packages designed by the state, given that some preventative services, including those provided by the NHS, will have a profound impact on care needs? By definition, these services would be provided before care needs arise, and therefore presumably before an individual care package can be determined. It may be necessary for the state to concentrate instead on providing certainty over the type of coverage it can provide free at the point of need, focusing at least initially on the care services that would be most difficult to deliver privately on a large scale. This would mean that those requiring lower-level interventions have a smaller proportion of their care costs met directly by the state. But the stateôs role in this regard, as will be explored in the next section, should be on empowering individuals, families and communities to deliver a range of services which in operation offer support to those with care needs, even if they are not traditional care services (see Kippin, 2010 for a discussion of care and ósocial productivityô).

It may be unwise, however, for the state to simply provide a range of services which some individuals may need regularly or permanently, and some individuals may never need. The amorphous nature of care needs would undermine the efficacy of such an approach. Instead, the stateôs contribution should be reconceived as a commitment to honouring certain entitlements. Demosôproposal for a social care constitution would be one way of enacting this (see Bartlett et al, 2009). Similarly, Emma Stone and Claudia Wood (2010) of the Joseph Rowntree Foundation have advocated a funding settlement based on outcomes rather than services, arguing that the way that funds to cover care costs are raised cannot be distinguished from the services these funds ultimately enable:

> We cannot isolate the ówhowô of care funding from the ówhatôis being fundedé a future care funding settlement must be able to fund and facilitate ï and even to incentivise ï the *type* of support people want.

Interestingly, Stone and Wood argue that the outcomes must at least partly be self-defined; the Beveridge approach to public services must give way to a user-centred approach in relation to long term care. They also say that models of co-payment, including private insurance products, could be óvery conduciveô to this user-centred system given that it enables individuals to commission the services they require more directly. However, they point out that insurance companies themselves, as well as the state, would have to redesign products on the basis of calculating the cost of achieving certain outcomes ï too often products are costed around certain services such as residential care. At the broad level of principle, therefore, the partnership approach has many benefits. The state should be looking to enhance and provide certainty over its role in funding care services, and this may involve detailing the proportion of care needs it will meet. But figures such as 50% or 66% should be little more than a rough guide to practice, and based not on a recognition of

the fiscal limits of state intervention but rather the practical limitations of social care as a state-provided public service.

Health and social care integration

One of the key arguments of this paper is that a sustainable funding settlement for long term care requires further attention to various issues around the delivery of long term care. The distinction between, and interdependence of, health and care provision is a crucial ófrontierôwithin the mixed economy of care.[11]

As public services, health and medical care (provided predominantly by the NHS) and social care (including long term care for older people) are separate entities. One of the most commonly voiced criticisms of the social care system is that recipients face uneasy transitions between different services, despite the existence of Joint Strategic Need Assessments involving both local authorities and Primary Care Trusts (see Featherstone & Whitham, 2010; Kippin, 2010). However, it is clear that, before they come into direct interaction with the care system, large numbers of people believe that long term care is provided free, funded through general taxation, and that the distinction between health and care is not widely understood. An Institute of Public Policy Research (IPPR) survey in 2009 found significant confusion in this regard. For instance, 45% of respondents believe that ómedical and health careôis part of the social care system, and 60% believe that ópsychiatric careôis a form of social care.

While they remain separate, it is not difficult to understand why the boundaries between the health and care systems are not fully understood. Clearly, there is a great deal of interdependence between the two, as outlined in a recent paper by Richard Humphries (2011). In an ageing society, a growing number of people have long term medical conditions with overlapping health and social care needs.[12] Care provision can assist the NHS by preventing emergency admissions and, in particular, facilitating earlier discharges from hospital. In some ways, the NHS has in recent years taken on greater care functions, in the form of continuing care (although concerns remain about fragmented services). However, the NHS could also be said to have partially withdrawn for its role in providing care through, for instance, the gradual closure of long stay wards.

As well as co-existing with health treatment in the continuum of care and support for older people, what we think of as social care can also play an important role in the provision of health care through preventative interventions. The essential proposition is that through the provision of care services, health conditions can be mitigated, or the most acute medical problems can be delayed. Many care services are indeed hospital-facing, as noted above. However, many of the most effective preventative measures are low-level, community-based interventions, intended to maintain the mobility and general well-being

[11] It is worth noting here that, according to the King's Fund, the productivity of adult social care services fell by over 15% in the decade up to 2010, compared to productivity losses of 2.2% for health and 3.3% for public services in general (Humphries, 2011).
[12] People suffering from mental health problems, falls and injuries, stroke symptoms, diabetes and asthma are among those most likely to utilise social care provision.

of older people. It is principally for this reason that the cost-effectiveness of preventative care spending is difficult to establish ï although these interventions are justifiable in themselves, in terms of quality of life improvements. However, analysis of the Partnership for Older People Projects (POPPs), a range of pilot initiatives designed to promote health and independence among older people part-funded by the NHS, by the Personal Social Services Research Unit (PSSRU) discovered that participants reported a decline in usage of a range of NHS services and therefore significant cost reductions (see Windle et al, 2009).[13] Conversely, the provision of more preventative health interventions can also reduce costs to the care system for conditions such as dementia. Dementia is a medical condition, but often 'treatment' takes the form of care interventions rather than medical interventions (see DH, 2009). The reality of separate health and care budgets may therefore help to explain why the NHS has thus far not invested sufficiently in preventative care for dementia.

For this reason, the Kingôs Fund have argued there is ña compelling argument for pooled budgetsô(Humphries, 2011). Any such development may, however, complicate the Kingôs Fundôs partnership model for long term care funding, given that it would problematise the designation of individual care packages, of which the state would fund a certain proportion. The need for closer integration between health and care therefore requires us to reconsider attempts to create a specific solution for long term care funding, and instead consider how to mobilise the stateôs resources in a more holistic fashion to support older people. This could be achieved at the individual level through more systematic joint assessments of the care needs of health patients, and vice versa. A framework of entitlements to care services, or more precisely entitlements to certain outcomes from care provision, could be conjoined with similar frameworks in operation within the NHS. Demosô idea for a care constitution was noted above; the recently established NHS constitution could represent a foundation to build upon in this regard.[14] Neither of these would, however, in themselves automatically achieve organisational change in the form of co-ordinated delivery or a more rational approach to budgeting. As such, it may be necessary to bring a greater range of care services specifically into NHS provision. This paper is not the place to discuss this idea in detail, yet it seems likely that an expansion of the health serviceôs responsibility for care would enjoy widespread legitimacy among the public, present opportunities for greater efficiencies within service delivery, and enable a more systematic approach to prevention ï as well as, crucially, providing a ready-made mechanism for the state to increase enhance its role in the funding of long term care through general taxation. Of course, many would argue that the NHS, while able to provide high quality specialist and emergency medical care, is not currently equipped to provide long term care given its inherently amorphous nature; there would also be legitimate concerns over the de-localisation of care that any ñtakeoverô by the NHS could otherwise represent.[15]

[13] Of course, reductions do not lead automatically to budgetary saving, given the fragmented nature of health and social care services.
[14] See www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx.
[15] Although the governmentôs plans for GP commissioning within the NHS may mitigate the latter possibility. See www.dh.gov.uk/en/Publica-

Another major delivery issue that will impact upon the funding of long term care is the personalisation agenda. A more user-centred approach to delivery is demanded by the amorphous nature of care ï it will not be possible to cater for all care needs in accordance with the categorisation of needs and services employed in provider-centred delivery. Obviously, as Stone and Wood argue, funding approaches that involve individuals interacting with the private sector to cover (portions of) their own cost ostensibly offer the clearest opportunities. Yet there has been an increasing move towards personalisation within public sector provision, with the widespread introduction of personal budgets. Moreover, schemes such as POPPs utilise a user-centred approach to preventative care (Centre for Policy on Ageing, 2011). In some ways, parts of the funding system for long term care are explicitly geared towards personalisation in long term care; the most obvious example is Attendance Allowance, a universal benefit for older people with disabilities, which effectively operates as a personal budget for purchasing care services. In theory, there is no rationale for the continuation of Attendance Allowance as a separate benefit; integrating the funds into the care system to enable a wider rollout of personal budgets as well as facilitate an expansion in responsibilities in care delivery for the NHS probably represents a more appropriate use of funds. However, given that Attendance Allowance allows user-centred provision ï and it is not yet clear how the NHS would maintain personal budgets for care services ï the case for immediate abolition of Attendance Allowance is questionable. This issue will be discussed further below.

Short term versus long term

In any process of large-scale public policy reform there is a 'transition dilemma' in terms of marrying long and short term objectives. Reform invariably creates losers as well as winners, so the process must allow time for those affected to become aware of the change taking place. Furthermore, even where the case for reform is straightforward, the logistics of delivery will be an inevitable constraint upon progress. Yet large-scale reform would not be required in the first place were it not for the severity or urgency of the problem being addressed. The dilemma has a particular resonance for public policies affecting retirement and later life: outcomes in post-retirement standards of living are often a consequence of decisions taken and circumstances experienced much earlier in the lifecourse. The need for change may be overwhelming, but the most desirable reforms for younger cohorts may be far less appropriate for older cohorts beyond or approaching retirement.

Long term care funding epitomises the transition dilemma. A closer integration of health and care, achieved principally via an expansion in the services provided by the NHS, was advocated above. Yet it is arguable that such change is feasible in a period of fiscal austerity, where the NHS is having to make efficiency savings of £15-20 billion over the next five years as a consequence of reduced investment and increasing demand. More generally, any solution which increased significantly the level of state funding via general

tionsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 and www.cfps.org.uk/news/cfps-news/?id=323.

taxation for long term care would face the charge of intergenerational unfairness, in that it would involve today's workers funding an enhanced care service for today's retirees. Similarly, it is not feasible to expect private sector funding mechanisms and community-based care provision, which will be discussed in the next section, to become affordable, high quality and trusted overnight. One of the reasons that a broad partnership approach is the correct approach for long term care funding is that it allows future generations the scope to adjust the boundaries between state, market and society in funding care. A social insurance or comprehensive model, on the other hand, seems to uphold an overly restrictive view of the state's role in funding long term care.

However, the pot fallacy means that a stricter version of the partnership model may inhibit innovation by future generations at the frontiers of health and care, formal and informal care, and between care and other services such as housing. The social insurance model is far less restrictive in this regard. Furthermore, crucially, James Lloyd's original design of the social insurance model for long term care funding was based on the premise that it would exist for a relatively short period of time. For Lloyd, it is important that 'the challenge is framed in terms of its historical specificity'. The desire for a 'once-and-for-all' solution assumes that different generations are 'substantially similar in crucial respects'; Lloyd's proposal was instead designed to address the unique historical problem of the retirement of the baby boomers ï the largest and arguably wealthiest cohort in history. Therefore, 'the development of one solution for todayôs older cohort does not preclude the development of other sustainable long-term care funding models for younger cohorts' (Lloyd, 2008a). This caveat was largely missing from the Labour government's presentation of the NCS and comprehensive approach.

There are strong grounds, therefore, to rehabilitate the NCF. What is required is a voluntary form of the NCF, running alongside the current system for a defined period. The enrolment fee structure would be broadly equivalent to Lloyd's plan for the NCF (while the baby boomers are collectively wealthy, they are also a highly unequal cohort, so means-testing must remain in the first instance), although it is probable that those likely to qualify for free support under the current system would not elect to join. Presumably, many wealthier individuals who could afford to self-fund their care under the current system, but who consider themselves unlikely to require care services, would also choose not to join. As the scheme matures, enrolment fees would be lowered (while remaining subject to means-testing), and the system of means-testing that governs eligibility for the current system would be tightened. As a result, more people would choose to join the NCF. During this maturation process, however, a mixed economy of care will have been emerging: the NHS will gradually have been taking responsibility for a greater range of care services, a private care insurance market will have emerged (supported by the state in various ways), community-based care provision will have become increasingly sophisticated, and the state's offer to informal carers will gradually improve. These developments will allow the voluntary NCF to close to new entrants, as the last of the baby boom generation reaches retirement. Figure 1 suggests how the population distribution based on the main source of

care funding for new entrants to the care system might look under these transitional arrangements.

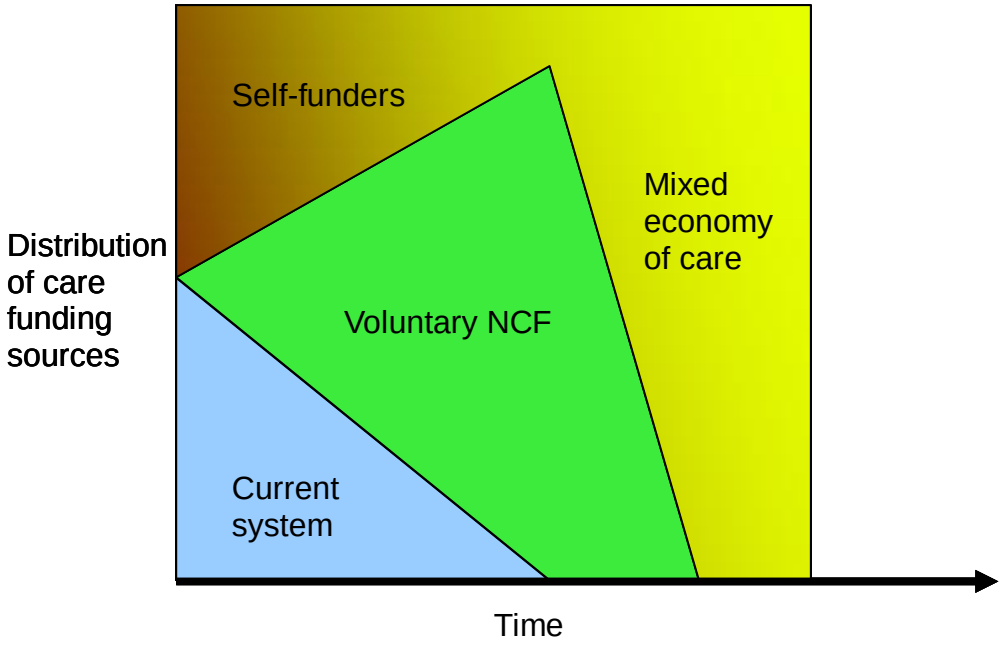

Figure 1: The role of a voluntary NCF in a mixed economy of care

Inevitably, the system in practice would be more complex than the above diagram suggests. Firstly, while the diagram appears to predict a decline in the number of self-funding new entrants, demographic change means that the numbers may remain fairly constant even if the proportion of self-funders within the care system. Furthermore, *how* people self-fund would change, as a larger market in care insurance products emerges to replace point-of-need payments. Moreover, the diagram details the distribution of founding sources according to the *main* source of funding for individuals. It is likely that many people within the voluntary NCF would engage with private sources of funding as the mixed economy of care emerges. Second, because the diagram shows the main source of funding, it does not distinguish the current or future role of the NHS. Yet it should be recognised that the NHS plays a small but important role in the current system, and in accordance with the argument of this paper, would play a greatly enhanced role in a mixed economy of care, not least as a proxy for a significant increase in the quantity of long term care funded through general taxation. Thirdly, the fairly rapid transition between the voluntary NCF and the mixed economy of care depicted in the diagram will be much more fluid in practice. It is likely that the boundaries between the two would be fairly permeable as the voluntary NCF matures, and that the architecture of a voluntary NCF would remain for some time, for the purpose of directing new entrants towards the plural funding system that will emerge. The success of private financing mechanisms such as a market in care

insurance products will ultimately determine the longevity of the NCF.

It is also worth considering again the role of Attendance Allowance under these transitional arrangements. Attendance Allowance is available to both self-funders and those dependent on means-tested support through local authorities. We know that the benefit would remain a key feature of the Wanless model of long term care funding, as a means of enabling individuals to make contributions to their own care package ï it is therefore redefined as separate or antecedent to the care funding system. In their revised partnership approach, the King's Fund advocates that Attendance Allowance is transformed into a means-tested rather than universal benefit (it would only be available to Pension Credit recipients) (Humphries et al, 2010). In this revised approach, Attendance Allowance itself remains antecedent to the care funding system, but the money saved by means-testing the benefit would in fact be brought into the care system, to fund personal budgets. In the alternative transitional arrangements outlined above, Attendance Allowance is considered part of the current system. It would therefore remain available in the short term to those not joining the voluntary NCF. The question of whether it would remain available to those within the voluntary NCF is not hugely relevant. Clearly, joining the voluntary NCF would enable individuals to a range of services and benefits, which cannot be detailed here. It is likely that elements of Attendance Allowance would be retained as part of this process, due at least in part from the demands of members and potential members. The more important question is whether Attendance Allowance would be retained in the long term, once the voluntary NCF has closed. As noted above, if personal budgets are rolled out widely, and an integration of health and care enables significant operational efficiencies, the rationale for Attendance Allowance is undermined. The King's Fund's concern for the poorest individuals under a partnership model are entirely understandable, but the notion of a care-related cash benefit lying outside the care funding system seems to introduce an unnecessary complexity. It would be preferable to support such individuals (and those with a higher cost of living) through the state pension, and income-related pensioner benefits. In the mixed economy of care, individuals (and their families) would utilise several means to make financial and non-financial contributions to their own care, many of which would inevitably involve the benefits system.

3. Beyond the state

Key points

- Private insurance has an extremely limited role in the current funding system, due in part to uncertainty over future funding arrangements, as well as a range of other supply-side and demand-side barriers. But it could play an important role in enabling user-centred care services within a mixed economy of care.
- Innovation in the annuities market would be necessary to establish a mass market, but it is also possible that pensions saving vehicles could be used to enable individuals to save more for care costs in later life.
- A second frontier in care delivery exists between formal care provision and a range of other services provided predominantly by the private and voluntary sectors; a future funding system must not inhibit innovations such as extra care housing.
- There is widespread public support for the continuing role of informal carers in long term care provision. Informal carers face significant difficulties, and support under the current system is inadequate.
- Formal and informal care are not functionally equivalent. The Scottish experience shows that increases in formal care provision do not lead to a reduction in informal provision. This understanding has been missing from the recent debate on long term care funding.
- To avoid inequality, a future funding system must take informal care provision into account when assessing needs, although provide higher levels of compensation and support to those informal carers substituting public sector provision.

Private insurance

Many of the proposed approaches to long term care funding would encompass a role for private insurers. Lloydôs original model would encompass a supplementary market in private insurance, and in practice individual contributions in the Wanless model would to some extent be made via pre-funded care insurance products. Policy Exchangeôs ôhybridô approach suggests that if the state were to match individual contributions, the most efficient way of doing this would be through co-payment of individualsô insurance premiums (Featherstone & Whitham, 2010). The pot fallacy, however, means this model could not work in any straightforward sense in practice; matching contributions depend on the stateôs assessment of the needs of actual care recipients, rather than the potential recipients that would buy pre-funded insurance products.

The current role of private insurance in the long term care funding system is extremely limited. The only care insurance products available in the UK today are immediate needs annuities (INAs).[16] The typical INA customer is aged 85, and at the point of entering residential care. They will purchase an INA for £80,000, for an annuity of £25,000 which is used to pay care home fees directly. Average life expectancy for those purchasing INAs is around 3 years (Mayhew et al, 2010). There are only around 5,000 INAs in force in the UK, representing 4% of the 120,000 self-funders in residential care (Lloyd, 2011b).[17]

[16] Private pension provision, in which insurance products play a crucial role, could be said to cover care costs for older people, although pensions provide a general retirement income and are payable whether the recipient has care needs or not. Equity release products arguably play a greater role in covering care costs, as will be discussed below, although these are not currently as popular as traditional pension products.

[17] According to Julien Forder (2011) of PSSRU, INA customers live for on average 2.4 years after purchasing a policy. However, the longevity

INAs cover longevity risk for those known to require care, that is, the possibility that an individual will not have sufficient wealth to pay for their care costs while they remain alive. They do not cover the risk of care needs arising in the first place. There are currently no pre-funded care insurance products, purchased before care needs arise, available in the UK. The final provider exited the market in 2010, although around 36,000 policies remain in force. Few countries have what can be described as a functioning market in pre-funded care insurance products. Around 10% of care recipients in the United States have pre-funded products, although the market has been heavily criticised. The figure for France is around 15% (Lloyd, 2011a). The Association of British Insurers (ABI) has argued that:

> Sales declined sharply after the Royal Commission over a decade ago. These products finally disappeared altogether from the market due to a lack of demand through a lack of certainty about the level of responsibility for meeting the cost of long term care (ABI, 2010).

As such, insurers cite the ongoing uncertainty over state provision as the reason for the withdrawal of pre-funded care insurance products. In terms of new products, Les Mayhew et al (2010) advocate disability linked annuities whereby annuity payments may rise depending upon the onset of care needs. They also suggest an 'accelerated' version of life insurance in which a lump sum would be paid in the event of death, but the policy would also fund a disability linked annuity for the holder if care needs arise before death.

There are of course many other barriers to the emergence of a functioning market in pre-funded care insurance, which contributed to the demise of pre-funded insurance products, and may inhibit future innovation.[18] Supply-side barriers which inhibit companies from developing and offering products include:

- Uncertainty over the extent or composition of future demand for care insurance products, due in part to uncertainty over the future relationship between life expectancy and health life expectancy.
- Uncertainty over future costs of long term care provision.
- Uncertainty over future design of care provision in the UK and the future role of informal carers; it is therefore difficult to design complementary products.
- Limited market profitability due to current market size.
- Costs associated with, and uncertainty as to the trustworthiness of, assessments of individual care needs.
- The reputational risk associated with decisions not to pay meet insurance claims of policy-holders in certain circumstances.
- Regulatory constraints such as Solvency II.[19]
- Lack of knowledge about long term care and/or care insurance products by independent financial advisors.

distribution encompasses a very long tail; many INA customers do not survive beyond a few months in residential care, but if they do survive this initial period, it becomes likely that they will live for a considerable number of years in care.

[18] These barriers have been outlined in exquisite detail by James Lloyd (2008a; 2011a), and readers are referred to Lloyd's work for a full discussion.

[19] See blog.ilcuk.org.uk/2010/05/04/solvency-ii-may-endanger-retirement-outcomes-for-future-pensioners/.

- The risk of adverse selection, that is, that demand for care insurance comes largely from individuals with a higher risk of care needs arising ï asymmetric information means that insurance companies may not be aware of the higher risk profiles of their customers.[20]

Demand-side barriers which inhibit individuals from purchasing products include:

- Ignorance of the risk that care needs will arise in the future, exacerbated by a lack of advice on risk and/or products, and a lack of financial capability.
- The unpredictable nature and extent of future care needs, and how much the required care services will cost; people may believe, justifiably, that even if care insurance is purchased, it will not cover the costs of their care in full.
- The complexity and high cost of care insurance products.
- The bequest motive, that is, a desire to preserve assets for future generations; some people may also expect to receive an inheritance from older generations which would cover the cost of care should need arise.
- A belief that long term care is funded entirely by the state through general taxation, or an expectation by individuals will qualify for free care under a means-tested system.
- A belief that family members will provide care informally, and/or a desire to preserve assets to support informal carers rather than surrender them to insurance companies to cover a need that may not arise.
- Distrust of financial services.
- Behavioural barriers such as hyperbolic discounting, whereby individuals exaggerate the value of the present and therefore discount the possibility of care needs and/or financial problems arising in the future.

In what ways could policy-makers seek to remove these barriers? For the ABI (2010), what is required most urgently is ôa clear statementô regarding the future settlement for long term care funding. It is only on the basis of greater certainty about the future responsibilities of individuals and the state that ôappropriate tailored provisionô could be introduced. The ABI has also called for a national framework for care assessments:

> By having consistent assessment criteria for care needs across all regions, the insurance industry would be better able to price risk and provide products that are more affordable. This would also allow for further innovation to improve products to reflect personal circumstances and needs.

Both demands speak to the need for certainty in the nature, level and funding of care provision through the public sector. A more universal framework for assessing care needs, establishing entitlements and measuring outcomes will be necessary for a functioning market in care insurance to develop.

[20] The risk of ôregulatory adverse selectionô should also be noted, whereby companies are prevented by law and/or social norms from gathering information form prospective customers, or using certain pieces of information in pricing. The recent European Court of Justice ruling which outlaws gender-based pricing of insurance products could have a significant impact on a future care insurance market. Indeed, it is possible that the court could also rule that age-based pricing is discriminatory, which would have an even greater impact. See uk.reuters.com/article/2011/03/01/uk-europe-insurance-idUKTRE7201O720110301

The state could also support the care insurance market by under-writing the tail risk, that is, guaranteeing to cover all care costs (and possibly hotel costs) for individuals after a certain amount of time (see Lloyd, 2011a). Insurers would be spared the risk that customers live for longer than expected, and as such premiums would in theory be significantly cheaper. However, it is possible that this intervention would remove the incentives for individuals to seek private insurance cover in the first place. The risk of care needs arising would remain, but if the state shoulders the longevity risk for all citizens, the most catastrophic risks are largely averted. The state could also seek to incentivise care insurance take-up by minimising the impact of insurance pay-outs on means-tested support. In the United States, individuals purchasing certain state-backed products have insurance pay-outs added to the eligibility threshold for means-tested support. If the threshold is originally *x*, and an insurance product provides *y*, the threshold would become *x+y*. Similarly, public authorities could disregard any insurance pay-out in assessing individual means. In both cases, this would involve the state in effect subsidising the care costs of wealthier individuals ï more likely to be able to afford to contribute to their own care costs without state support (see Lloyd, 2008a). As such, not only is it extremely unclear whether a mass market in care insurance products will emerge, it may be undesirable for the state to directly incentivise take-up of these products.

There are reasons to believe that a mass market could emerge without direct incentives. With a new bedrock of certainty over the state's role in financing long term care, the groth in the number of people with defined contribution (DC) pensions saving, coupled with a growing awareness of care needs in later life, could allow the market to grow more organically. Unlike defined benefit (DB) pensions, DC provision offers individuals more control over how their savings pots are converted into a retirement income, through annuitisation. There are legitimate concerns over the demise of DB pensions, but while DC pensions require that individuals rather than their employers bear the investment risk, annuitisation still enables individuals to pass the longevity risk onto insurers. Of course, the government is currently implementing measures to increase DC pensions saving, particularly among young people, chiefly via the National Employer Savings Trust (NEST) and 'automatic enrolment' into an occupational scheme, which would essentially extend already-existing incentives to a larger group of employees. The annuities market will grow as a result, and it is possible that many annuitants will demand products that involve coverage of care needs, as well as providing a general retirement income. The planned increase in the state pension to around £155 per week will bolster the retirement income provided by the state to many millions of people, and should mean that many individuals are able to use their private and occupational pensions saving in more novel ways. We should not, however, exaggerate the possibility of using annuities to fund care services. There remain a range of supply-side and demand-side barriers to annuitisation in general, not least of which is cost, especially for products linked to care needs (see Boardman & Blake, 2010; Wells & Gostelow, 2010). We also know that older people face particular barriers in seeking to 'shop around' for the right insurance products (see Sinclair, 2010). More fundamentally, if annuities are used to fund care services, it will reduce the amount

available to fund a general retirement income, that is, the main rationale for pensions saving. This may be inevitable to some extent, but nevertheless would represent a far from ideal outcome for any long term care funding system.

If bringing pensions and long term care closer together is desirable, to some extent, at the point of annuitisation, could it also be possible and desirable for pensions and care to be more closely linked during the accumulation phase? It is possible that pensions saving mechanisms could be used in a more direct fashion to enable the accumulation of assets to be used specifically to cover care costs. Simply, pensions saving vehicles could offer individuals a vehicle for saving towards potential care costs over their lifecourse. The accumulated funds could be combined with pensions saving at retirement to purchase a pre-funded care insurance product, or indeed retained in the scheme and used to purchase an INA at a later point.[21] It is of course highly unlikely that employers would be willing to contribute to care savings in the way that they contribute to pensions saving ï or that individuals would demand such contributions from their employers. However, there remain three key reasons for optimism regarding the possibility and desirability of utilising pensions saving vehicles in the development of a market in care insurance products: first, the introduction of NEST represents a unique opportunity for positive branding around saving for retirement ï bringing care and pensions saving closer together would enable the long term care system to benefit from this development. Secondly, it would provide an already-established mechanism for allowing individuals to accumulate care savings over their working life. And finally, utilising pensions saving mechanisms could enable the long term care funding system to mitigate the discrepancy over the appropriate referent for the funding system (that is, individuals, families or households), by allowing individuals in certain circumstances to use their personal care savings to cover the care costs of a spouse or dependent.

The possibility that NEST itself could be used to enable care savings, alongside general pensions savings, is intriguing. However, this possibility would require extensive consideration which is beyond the scope of this think-piece. What can be said, initially, is that NEST is not accessible to all employees, and that it will be important that any attempt to use NEST to enable care savings does not detract from the central purpose of the scheme. On the other hand, there is an intuitive appeal to a single, private savings mechanism for the cost of living in later life ï it may undermine the legitimacy of the notion of private contributions to care costs in later life if individuals are asked to save for care separately to general retirement saving.

It is also worth noting here Les Mayhew et al's proposal, amid concerns that private insurance products would be inaccessible for the poorest households, for long term care bonds (LTCBs). LTCBs would resemble already existing National Savings and Investment (NS&I) premium bonds. The bonds could be purchased at any stage of the lifecourse, but they are cashable only when care needs arise (or needs beyond those met by state

[21] Alternatively, under the social insurance or comprehensive approach to long term care funding, care saving through a pensions saving mechanism could be used to fund the NCF/NCS enrolment fee.

provision). Crucially, a portion of the purchase price would be placed into a regular prize fund to incentivise take-up (see Mayhew et al, 2010). Of course, LTCBs are an insurance product, they would not involve micro-level interaction between individuals and insurance companies. However, private insurance companies would play a role at the macro-level in delivering LTCBs, as they do in relation to NEST, and indeed would do under the social insurance or comprehensive approach to long term care funding.

Clearly, private insurance could play an important role in the mixed economy of care funding. It would be inappropriate to conceive of this role as a substitution for the state, but nor would its role simply be to supplement state provision for more affluent individuals.[22] The amorphous nature and uncertain course of care needs demands plurality in funding mechanisms. Certainly, given the transformations required in state provision, private insurance could play a key role in enabling individuals to contribute more to their own care costs in the short-to-medium term. If the market fails to deliver, future generations will retain the option to enable the state to take on greater responsibilities for care funding. It is important to note here, however, that it is difficult to imagine private care insurance playing a significant role in funding care, in the short term, for baby boomers approaching retirement. As such, a form of the state-backed NCF will remain necessary. Crucually, however, one of the main advantages of establishing the NCG is that it will institute an architecture around the care funding system that could be used in future years to help to nurture a fully private market in care insurance.[23]

The second frontier

If we are to take seriously Emma Stone and Claudia Wood's proposition, noted in the previous section, that we cannot separate the 'how' of care funding from the 'what' of delivery, it is clearly necessary for any settlement on long term care funding to enable (or at least not inhibit) the kind of care services and delivery mechanisms considered effective and desirable by recipients. The blurred distinction between the formal provision of long term of care services (and the funding system) and the range of services and activities that may contribute to care provision represents a second 'frontier' within the mixed economy of care.

There are signs that the coalition government recognises this frontier in various ways. Most significantly, the role of communities and 'active citizenship' was identified as important to current and future long term care provision in the Department of Health's 2011 white paper on adult social care. There are clear links, therefore, to the Conservative Party's wider 'big society' agenda. The white paper identified Southwark Circle as an

[22] It should also be noted here that individuals will not necessarily be required to pay up-front fees for all private care insurance products. The variety of payment methods, including deferred payment, suggested as part of James Lloyd's NCF enrolment fee could also apply to private insurance, even where products are 'pre-funded'. We can expect the private sector to innovate further on payment mechanisms, given the opportunity.

[23] In fact, in his latest proposals for the NCF, James Lloyd has argued that private insurance companies would be crucial to operation, in that they will sell annuities to the Fund which would be used to pay for individuals' care. This would represent a large expansion of the role of private insurance in care, although would not require individuals themselves to purchase care-related annuities from insurers (see Lloyd, 2011c).

example of the kind of community organisation that can help with care provision.[24] Members of the Circle gain access to a range of user-initiated social activities, and can also purchase tokens for practical support to facilitate a healthy, mobile and independent lifestyle from voluntary 'neighbourhood helpers'. The white paper referred also to the concept of 'time-banking' and other complementary currencies, whereby individuals providing practical assistance and support within their communities can bank resources such as the time spent in helping others, and draw upon it in future in order to receive help from others when required.[25] Indeed, many local authorities are now utilising sophisticated 'slivers of time' technology to match volunteers to older people in need of low-level support.[26] This is not simply about mobilising the role of volunteers within (broadly defined) care delivery, but fundamentally also about providing services voluntarily as a direct, yet non-financial, way of funding the costs of one's own care.

Clearly, strictly speaking such activities may not be care services, and therefore their interaction with the current funding system, and indeed any system which embodies the pot fallacy or incorporates means-testing, remains uncertain. Would receipt of these services beyond the boundaries of formal care provision be taken into account, as informal care support by relatives is, when local authorities determine the severity of an individual's care needs? Would the resources, such as time, that are banked under complementary currency mechanisms be taken into account in assessments of an individual's financial means? Would the membership fee for schemes like Southwark Circle, or the time spent volunteering, count towards an individual's contribution to their own care package under the Wanless partnership model? Underpinning each of these questions, of course, is the problem that the services provided by such schemes cannot neatly be defined as care services. Yet as Henry Kippin (2010) reminds us, the kind of needs that we think of as care needs are of often the result not of a specific, personal condition, but rather arise in many cases from community breakdown. These schemes therefore provide care by tackling the underlying causes of care needs ï challenging the boundary not only between formal and informal care but also, because the act of receiving or experiencing the service is in itself therapeutic for the recipient, between inputs and outputs in care delivery.

The white paper also refers to the creation of a partnership between formal care services and other support services, such as housing, and the Dilnot Commission has vowed to make its funding solutions compatible with the role of housing in care delivery. This seems to conflict with many of the models for long term care funding that have been proposed, including the Conservative Party's original proposals for a voluntary insurance scheme, which bracket off accommodation or hotel costs for those requiring residential care. The National Care Fund, for instance, recognises that housing wealth will be required to fund enrolment fees, although explicitly excludes hotel costs from coverage by the Fund (although arguably this is a short term scenario based on the exceptional housing circumstances of near-retirement baby boomers).

[24] See www.southwarkcircle.org.uk/
[25] See www.timebanking.org/
[26] See www.nesta.org.uk/areas_of_work/public_services_lab/reboot_britain/assets/features/person-to-person

Obviously, in the short term, the care funding system will have to continue to draw distinctions between those that require residential care and those that do not. In the long term, however, it would be preferable for this distinction to be increasingly minimised within a plural funding system. Innovations such as 'extra care' housing could transform the way that care is delivered to older people. Extra care, which is provided predominantly by the private and voluntary sectors, exists in the space between residential care and sheltered housing, with care services delivered on site within extra care housing developments. As a relatively recent innovation, evaluations of extra care remain limited. However, there is a growing evidence base, arising from research by PSSRU, that extra care improves the social well-being of residents, and given that older people typically move into extra care housing before the onset of severe care needs, that extra care can delay the onset of the most serious health and care needs (see Darton et al, 2008; Callaghan et al, 2008). Yet while there is some evidence that extra care housing creates efficiencies for external health and care workers visiting patients resident within extra care schemes (Bäumker et al, 2008), the evidence on cost-effectiveness remains limited. However, the International Longevity Centre-UK is currently conducting research on the costs of various extra care schemes in comparison to other health and care services. Emerging results suggest that an expansion of extra care housing provision (currently extra care accounts for less than 1% of older peopleôs housing) could transform the costs of long term care for the state and individual recipients by postponing the need for institutional care. The funding system must therefore not serve to inhibit this development by institutionalising the barriers between care and housing provision.

Housing is part of an array of services that interacts with the care system. Most immediately, the concept of lifetime neighbourhoods combines a recognition of the importance of housing to a wider recognition of the importance of place and community to older people's quality of life (CLG & ILC-UK, 2007). More generally, care and support providers for older people are increasingly working with more 'universal' service providers, such as holiday companies, or providing such services themselves. Demos research into the potential impact of personal budgets within care budgets, based on a survey of potential beneficiaries, finds that personalisation would lead to greater portions of the care budget spent on universal services such as leisure, transport, and practical support at home (see Wood, 2010). It seems likely, therefore, that the marketplace for care services will become more sophisticated, and more difficult to distinguish from the consumer marketplace in general ï whether consumption is funded through the state or by individuals themselves. This clearly problematises the notion of a quantifiable care package and even, although perhaps to a lesser extent, the notion of a National Care Service as envisaged by the previous government. It is crucial therefore that the long term care system is centred on the user as far as possible. Personal budgets funded by the state will be important in this regard, although so too will private sources of funding which remain entirely within the control of individuals and their families.

The third frontier

The role of informal carers represents a third main 'frontier' in care delivery. In providing care valued at around £70 billion, informal carers' role in funding care for older people, albeit by non-financial means, is crucial. Informal care straddles the distinction between funding and delivery, and therefore the role and perspective of informal carers has too often been overlooked in the debate on long term care funding.

Informal carers receive very limited support from public authorities. Carers' Allowance is a benefit available to individuals providing care for more than 35 hours per week for someone in receipt of certain disability benefits. Carers' Allowance is not available to people who earn more than around £100 per week, or are in full-time education. Pensioners in receipt of basic state pension £59.30 or over per week are also unable to receive Carers' Allowance, but may be passported onto the carers' premium within Pension Credit and other means-tested pensioner benefits. Around half a million people are in receipt of Carers' Allowance, which costs the state around £1.5 billion per year. Some care recipients pay for carers through direct payments (a forerunner of personal budgets) but are only permitted to employ relatives in exceptional circumstances. As James Lloyd (2010) has argued, Carerôs Allowance assumes poverty-level earnings, and is therefore éeffectively meaninglessôas an earnings-related benefit. This is one of the reasons, despite the limited pool of eligible recipients, that take-up is low.

Caring responsibilities may create significant financial problems for informal carers. Qualitative research conducted by Hilary Arskey et al (2005) for DWP found that carers find it difficult to combine work and retirement, leading to ôde factoôretirement for many. Planning ahead, and returning to work once caring responsibilities end, are particularly problematic. According to a survey undertaken by the NHS Information Centre (2010), around 12% of people provide some informal care, representing around 5 million people in England, for adults with a disability or illness.[27] Around half of carers provide more than 20 hours per week of care. Those providing a high quantity of care are less likely to be in employment, and more likely to be older. Although 83% of carers provide care for only one person, this leaves 17% of carers with care responsibilities for more than one person (including 3% responsible for three or more). The survey findings showed that caring responsibilities can have significant negative effects on many carers: more than half said that their own health had worsened since the onset of caring responsibilities, and more than 40% said that their personal and social life had been negatively affected. Crucially, only 11% of carers surveyed were in receipt of CarersôAllowance, although more than a quarter were themselves in receipt of disability benefits, and only 6% had been offered a carerôs assessment by their local authority. For those providing more than 35 hours of informal care per week, 23% receive CarersôAllowance, and around half receive disability benefits. A survey of the informal carers of self-funders commissioned by the Putting People First Consortium found this group faced particular difficulties over lack of information and guidance, as well as financial concerns. Interestingly, carers portrayed

[27] Around half of these carers provide care for someone they live with, and the same proportion are providing care for someone aged 75 or over.

greater levels of anxiety than care recipients themselves (see MHA, 2010).

The Department of Healthôs white paper suggested that increased support for informal carers is one of the governmentôs key priorities in terms of adult social care.[28] However, the main plans in this regard concern increased support for respite care. The lack of respite for informal carers is a significant problem, yet nevertheless the government does not yet appear to be considering significantly increasing the support available to informal carers more generally. According to IPPR, the public would to prefer to receive care services from professional carers rather than family and friends. IPPRôs survey, cited above, reported that 45% of people in Britain would favour care provided by professional staff. However, around 40% would actually prefer their relatives and friends to provide care. IPPRôs report did not consider the former statistic particularly significant, because it is split roughly between those who would prefer informal carers to be paid, and those who would prefer informal care to be provided voluntarily. This distinction is clearly misleading, given that in general informal carers, where they are paid, are not paid directly by care recipients or even those arranging care such as local authorities. Informal care, perhaps by definition, is provided voluntarily ï but this does not mean that carers should not be compensated through the benefits system for the opportunity cost of working less or not at all. Therefore, it is fair to say that that there is strong support among the public for the continuing role of informal carers in care provision, although this is notwithstanding the support that exists simultaneously for increasing professionalisation in care provision (the two should not be seen as either/or).

Lloyd (2010) has set out a plan for supporting informal carers as part of a ôco-productionô of long term care. In the short term, the earnings cap should be raised to £136.54, to allow earnings equivalent to the national minimum wage for informal carers, and carerôs assessments by local authorities should become mandatory. In the long term, the care system should disregard all informal care provided by those aged under 16 or over 75 in determining the severity of a potential care recipientôs needs. All informal carers should be offered a personal budget to fund at least one day off per week. Carerôs Allowance should be replaced by a universal benefit, delivered via a national system of carerôs assessments. The care system should also disregard any care provided by an informal carer when they are already providing care for more than 60 hours per week.

However, it is argued here that the current care system upholds an erroneous assumption regarding the functional equivalence of formal and informal care, by taking the quantity of informal care available into account when determining an individual's care needs. Both the strict partnership and social insurance funding models appear to maintain this assumption. Of course, public authorities providing and arranging care will need to some extent to continue to take informal care into account when determining the quantity of formal care required, because it would be unfair to those without access to informal care if it were entirely disregarded in needs assessments ï it is on this basis, however, that the ôofferô to

[28] The Welsh Assembly Government has been more active in outlining its plans for supporting older carers. See http://wales.gov.uk/topics/olderpeople/publications/carersactionplan2007?lang=en

informal carers should be improved, along the lines detailed by Lloyd. But in reality formal and informal care are not functionally equivalent. Evidence from the Scottish experience of free personal care is worth noting. In a review for the Joseph Rowntree Foundation utilising the British Household Panel Survey, the Family Resources Survey and qualitative research, David Bell and Alison Bowes (2006) found no evidence of ósubstitutionô, that is, there was no reduction in informal care provision despite the substantial expansion of formal provision.[29] Instead, the introduction of free personal care appears to have enabled some carers to provide more care, and for a longer period, through enabling them to concentrate on meeting care needs not covered by personal care services. Crucially, recipientsôaccounts of informal care place it within the context of ongoing, committed, familial relationships, that is, beyond simply the provision of care in any straightforward sense. Many recipients preferred some tasks to be undertaken by professionals rather than family members, but equally also valued the individualisation of care provision enabled through informal care.

This evidence seems to reflect the amorphous nature of care needs. The provision and professionalisation of formal care does not inhibit informal care, but rather may provide a firmer foundation for the provision of informal care. This is not to say that we should not seek ways in which to ease the burden upon informal carers, but it is apparent that informal care will always play a key role in the care system, delivering forms of care that formal carers will be largely unable to provide, at least not as effectively or cost-effectively. The funding system should reflect this reality. Few of the models that have been proposed in recent years seem to achieve this. Under the Wanless partnership model, it is unclear whether support for informal carers is part of the stateôs funding of half or two-thirds of the individual care package, or indeed if it is considered part of the individualôs contribution that the state will match. In practice, informal care would continue to play a role broadly similar to under the current system; the problem with this is that therefore the funding settlement itself provides no grounds upon which to improve the offer to informal carers, and they would remain a secondary consideration within care funding. Lloydôs social insurance model is preferable in that the NCF could be used to fund a much improved offer to informal carers, but it remains that the structure of enrolment fees would be determined on the assumption that formal and informal care are functionally equivalent; those with access to informal care would receive fewer services paid for directly by the Fund, despite the fact that formal care provision seems to enable rather than replace informal care provision.

[29] See also Bell et al (2006).

Conclusion

In surveying the debate on long term care funding, this paper has argued that we need to consider a wider array of issues related to the delivery of care before a fair and sustainable funding settlement can be reached. Long term care is not an intervention in itself, but a type of intervention for addressing needs that are invariably amorphous. There are various 'frontiers' of care provision which defy both the construction of rigid blueprints for long term care provision, and the delineation of specific care packages for each recipient. The frontiers discussed in this paper are those between care provision and medical or health services, between formal and informal care, and between care and a range of more universal services such as housing. As such plurality in funding long term care must be retained. ILC-UK's earlier proposals for a social insurance-based funding settlement have been revisited here, given the apparent unease among the current government and various stakeholders towards a funding model which would be complex for users, and could entrench means-testing. But the think-piece has advocated a form of James Lloyd's National Care Fund in the short term in order to ease the transition between the current system and a broader partnership approach, or a mixed economy of care, in which individuals would take on greater responsibility for funding their own care. This responsibility would be based, however, on the types of care services required rather than, as under the current system, financial means.

In terms of the long term, the paper has advocated that health and care provision become much more closely integrated. This is partly due to the efficiencies that can be achieved by bringing certain services and budgetary arrangements within the health/care continuum closer together. But it also provides for a fair and legitimate funding mechanism for meeting the most acute needs for older people, that is, general taxation. There should not be, however, a steep cliff-edge between the care services that the state provides, and the services that individuals are required to arrange and fund themselves. Care provision, even if it comes under the rubric of the NHS, must be flexible, personalised and outcomes-based, taking into account severity of need, and based on a system of entitlement rather than a strict delineation between the care services the NHS will and will not provide.

Nevertheless, a mixed economy of care will require and enable many individuals to arrange and fund their own care services within the private and voluntary sectors, and within families and communities. A larger market in care insurance products has the potential to emerge to enable individuals to top up state provision – there are things that the state can do to enable this development (it may be possible to utilise pensions saving mechanisms in this regard), but to some extent it will manifest organically once the wider funding system is concretised. The point here is that we should not resist the development of care insurance as a key aspect of the long term care funding system, given the opportunities for user-centred care that will result from any products where individuals remain in charge of the purse strings as far as possible. Crucially, it may be that only by allowing individuals and their families to retain some financial control that the boundaries

between care and other services, such housing, transport and even leisure, will be permeated.

Informal care by friends and families will also remain vital to both the funding and delivery of long term care to older people; it will be particularly important for those unable to top up state provision by financial means. More generally, informal care allows individuals and their families to design more personalised provision. As such, the offer made by the state to informal carers (in terms of both finance and wider support) should be increased significantly over the long term, especially where family members are substituting for formal care provision.

References

Arskey, H et al (2005) *Carers' Aspirations and Decisions Around Work and Retirement* (DWP).

Bartlett, J & Guglielmi, S (2009) *A Constitution for Social Care* (Demos).

Bäumker, T et al (2008) *Costs and Outcomes of an Extra Care Housing Scheme in Bradford* (Joseph Rowntree Foundation/Personal Social Services Research Unit).

Bell, D & Bowes, A (2006) *Financial Care Models in Scotland and the UK* (Joseph Rowntree Foundation).

Bell, D et al (2006) 'Did the introduction of free personal care in Scotland result in a reduction of informal care?', paper presented at The Well-Being of the Elderly, IZA workshop, 22 May 2006, available at http://www.esrc.ac.uk/my-esrc/grants/RES-342-25-0006/outputs/read/33a81c41-9a5d-4b84-8531-157c966ef8a0

Berry, C (2010) *The Future of Retirement* (International Longevity Centre-UK).

Boardman, T & Blake, D (2010) 'Spend more today: using behavioural economics to improve retirement expenditure decisions', Discussion Paper PI-1014, Pensions Institute, Cass Business School.

Buckner, L & Yeandle, S (2007) *Valuing Carers: Calculating the Value of Unpaid Care* (Carers UK).

Callaghan, L et al (2008) *Social Well-Being in Extra Care Housing: Emerging Themes* (Joseph Rowntree Foundation/Personal Social Services Research Unit).

Centre for Policy on Ageing (2011) *How Can Local Authorities With Less Money Support Better Outcomes for Older People* (Joseph Rowntree Foundation).

Darton, R et al (2008) *Evaluation of the Extra Care Housing Funding Initiative: Initial Report* (Personal Social Services Research Unit).

Department of Communities and Local Government and International Longevity Centre-UK (2007) *Towards Lifetime Neighbourhoods: Designing Sustainable Homes* (CLG/ILC-UK).

Department of Health (2000) *The NHS Plan: the Goverment's Response to the Royal Commission on Long Term Care* (The Stationery Office).

Department of Health (2009) *Living Well With Dementia: A National Strategy for Dementia* (The Stationery Office)

Department of Health (2011) *A Vision for Adult Social Care: Capable Communities and Active Citizens* (The Stationery Office).

Featherstone, H & Whitham, L (2010) *Careless: Funding Long term Care for the Elderly* (Policy Exchange).

Forder, J (2011) 'The role of the immediate needs annuity', paper presented at Mind the Gap: Paying for Self-Funders conference, London, 24 March 2011, available at www.policyreview.tv-/conference/535.html.

Humphries, R et al (2011) 'Partnership models', paper presented at Mind the Gap: Paying for Self-Funders conference, London, 24 March 2011, available at www.policyreview.tv/conference/535.html.

Humphries, R et al (2010) *Securing Good Care for More People* (The King's Fund).

Humphries, R et al (2011) *Social Care Funding and the NHS: An Impending Crisis?* (The King's Fund).

IPPR (2009) *Expectations and Aspirations* (IPPR).

Kippin, H (2010) *Social Care 2020: What Are the Challenges Ahead?* (2020 Public Services Trust).

Lloyd, J (2008a) *A National Care Fund for Long term Care* (International Longevity Centre-UK).

Lloyd, J (2008b) *Funding Long Term Care: The Building Blocks of Reform* (International Longevity Centre-UK).

Lloyd, J (2008c) *National Care Fund: Supplementary Paper 1* (International Longevity Centre-UK).

Lloyd, J (2010) *Towards a New Co-Production of Care* (Strategic Society Centre).

Lloyd, J (2011a) *Gone for Good? Pre-Funded Insurance for Long Term Care* (Strategic Society Centre).

Lloyd, J (2011b) *Immediate Needs Annuities: Their Role in Funding Care* (Strategic Society Centre).

Lloyd, J (2011c) *Delivering a National Care Fund* (Strategic Society Centre).

Martin, D (2010) *Abolish NICs: Towards a More Honest, Fairer and Simpler System* (Centre for Policy Studies).

Mayhew, L (2010) 'The role of private finance in paying for long term care' in *The Economic Journal*, vol 120, pp 478-504.

Melanie Henwood Associates (2010) *Journeys Without Maps: the Decisions and Destinations of People Who Self-Fund* (Putting People First Consortium).

NHS Information Centre (2010) *Survey of Carers in Households* (NHS Information Centre).

Royal Commission on Long Term Care (1999) *With Respect to Old Age: Long Term Care: Rights and Responsibilities* (The Stationery Office).

Sinclair, D (2010) *The Golden Economy: The Consumer Marketplace in an Ageing Society* (Age UK/International Longevity Centre-UK).

Skills for Care (2010) *The State of the Adult Social Care Workforce 2008* (Skills for Care).

Stone, E & Wood, C (2010) *A Funding Settlement that Works for People, Not Services* (Joseph Rowntree Foundation).

Wells, J & Gostelow, M (2010) *Annuitisation Process and Consumer Detriment* (Financial Services Consumer Panel).

Windle, K et al (2009) *National Evaluation of Partnership for Older People Projects: Final Report* (Personal Social Services Research Unit).

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