



## Fit for the Future: A new vision for older people's care and support

Counsel and Care Policy Discussion Paper 1

Jessica Asato, October 2006

**Jessica Asato Consulting**

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## Author's acknowledgements

Many thanks must go to PricewaterhouseCoopers for kindly hosting a seminar in September 2006 which helped to inform the development of this paper, and in particular to John Hawksworth, Lucinda Beesley, Nicky Leach and Rubina Lawson. David Walker did an excellent job chairing the roundtable discussion itself. Thank you also to Sue Collins from the Joseph Rowntree Foundation, Emily Holzhausen from Carers UK and Alison Williams from Tunstall for their advice and comments. Lastly, thank you to Stephen Burke, Caroline Bernard and Elizabeth McLennan at Counsel and Care who provided intellectual direction and a critique at draft stage.

## Author's biography

Jessica Asato is an independent health and social care researcher. She published *The Future of Long-Term Care Financing - Facing the Reality* in March 2006 and has helped with research for a major one-day conference on the value of early intervention in older people's services. Previously Jessica was a researcher at the Social Market Foundation think tank where she edited reports on co-payments in public services, healthcare funding mechanisms, public health, the regulation of healthcare professionals, and patient information. Jessica is a member of the Fabian Society Executive, a Trustee of Brook young people's sexual health charity, and Chair of Governors at Jack Taylor Special School in Camden.

## Foreword

This Discussion Paper is the first in a series from Counsel and Care looking at the current situation, policy threads and future trends in relation to older people and their care and support needs. Its aim is to draw together the current strands of policy thinking in this area, particularly in the lead up to the Comprehensive Spending Review 2007. In this pre-CSR climate, it is essential to draw together recent discussion, reports and proposals with the aim of presenting an overarching vision for the future of care and support for older people, and in particular how this is to be funded in the years to come. Bringing together key organisations and individuals to brainstorm, highlight issues which have yet to be resolved and attempt to reach some conclusions is an essential part of any future settlement.

Counsel and Care is well placed to coordinate such a discussion. With a fifty-two year track record of providing advice about care and support to older people, their families and carers, the national charity has a wealth of experience to contribute. The advice service currently reaches around 25,000 people each year, and the charity gathers these experiences to inform its lobbying and campaign work.

Independent health and social care consultant, Jessica Asato, was commissioned to write this paper, which was the subject of a roundtable discussion between Counsel and Care, and other charities, organisations and government departments working for the benefit of older people. The final version of the policy paper incorporates the ideas generated at the policy roundtable, and fleshed out through later discussion and research.

Our thanks to Jessica Asato for all her hard work on the paper.

## Introduction

The debate about funding older people's care has been given a much needed kick-start by the launch earlier in 2006 of Sir Derek Wanless's Review of Social Care, and the Joseph Rowntree Foundation's final report on funding long-term care. On television we have seen Tony Robinson's moving account of his mother's dementia on Channel 4, and the powerful Panorama exposés on continuing care and the sale of people's homes to pay for care, helping to propel the plight of older people and their families into the limelight. The key challenge, however, will be to continue the momentum for a change in the system of funding and support for older people, their families and carers, at a time when funding for public services in general is tightening.

The outcome of the Department of Health's review of social care will play an important role in keeping the agenda alive. It has to find answers to questions such as who should pay for care, and which supplementary products such as equity release and care vouchers might help. If it succeeds, it will strengthen the case for increased funding and support in the Treasury's comprehensive public services spending review in 2007. This is only the second time the Labour Government has faced a CSR which entails a fundamental rethink of its political priorities and the implications for changes in public spending. The CSR will not just map out the Government's spending priorities for the next three years; it may also determine the outcome of the next election. As the older population increases, it will become harder for politicians to ignore the poor quality of service faced by many older people. This makes the question of how to fund older people's care a political as well as a social one. Politicians ignore at their peril the growing feeling of injustice among older people and their families and carers. Waiting for another three years to pass without acting is not an option if the funding problems of the present and the future are to be effectively tackled.

If policymakers are to find a sustainable and fairer solution to the funding of older people's care, there has to be a good analysis of problems we face and

the case for change. At the heart of this debate are competing notions of what constitutes an equitable outcome. On the one hand many older people, who have worked hard to save and invest in property, feel let down by the state when they discover they must pay for most or all of their care. On the other hand those people who have not had the opportunities to save find themselves reliant on an underfunded system of care which is failing to provide them with adequate choice and independence in their old age. If the gap between those who have assets and those who do not contributes to the reduction of social mobility in the UK, it could be argued that those who have wealth should use it to fund their care, while public resources are directed towards the poorest in society. The use of housing equity to pay for care grows in importance as a potential policy objective for the government.

The Labour Government has been in the main a redistributive one - for example channelling public money to poorer pensioners through the Minimum Income Guarantee, and to working parents through the Tax Credits system. When the Government rejected the majority view of the Royal Commission investigation into funding older people's care, it was a reflection of a general philosophy that where people *can* access resources, they should carry the responsibility of doing so. These arguments have not been successfully communicated outside of the confines of Westminster policy circles, however, and the public are either ignorant or unconvinced that such values should drive policy on the funding of older people's care. In essence, the Government has failed to hammer out a contract with the public which specifies the rights and responsibilities of individuals, their families, the community and the state in relation to paying for care. This is compounded by a lack of information about available choices and care pathways, and advocacy for older people, their relatives and carers, which results in older people receiving care unsuited to their needs. It is no wonder that older people and their carers feel bewildered and dissatisfied with the status quo.

The changing demography of the nation makes the need for a care settlement an urgent one. The older population is currently growing twice as fast as the population as a whole. The growth rate for the total population was 0.4 per

cent between 2002 and 2003, while the rate for people aged 50 and over was 0.8 per cent, and the rate for people aged 65 and over was 0.7 per cent.<sup>1</sup> A large proportion of future growth will be as a result of the retirement of the 'baby boomer' generation who will have markedly different expectations and needs compared to previous generations. Not only will baby boomers have more wealth than previous cohorts: they are more likely to have a consumerist approach to questions of care and support in their older age. This could create inequalities if poorer people are less demanding about standards of care, and therefore receive poorer quality provision from the state. Any debate about funding care, therefore, must be about raising standards for all rather than simply responding to the demands of an articulate older population. It must also be about how we can tailor care and support to the needs of socially excluded older people.

Another issue which causes tension is localism. On the one hand, the Labour Government has been accused of being too centralised, creating national targets which fail to recognise complex differences at a local level. On the other, differences in charges for care and eligibility criteria between local authorities have raised questions about whether stronger national prescriptions are needed to guarantee fairness geographically. Any settlement would have to delineate the responsibilities of national and local government more clearly to enable service users to make informed decisions about their future care needs.

Finally, the current support system for informal carers fails to encourage families and the wider community to offer care, and also to integrate carers into the workforce. As the population ages, employers will have to increasingly rely on an older workforce; but at the moment around three million carers are aged 50 and older, and the probability of becoming an older carer is a one in seven chance for men and one in six for women.<sup>2</sup> Employers will increasingly find themselves with employees who also have caring responsibilities who will demand flexible working and benefits or who may drop out of employment

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<sup>1</sup> Quoted in Age Concern's *The Age Agenda 2006, Public policy and older people*, March 2006

<sup>2</sup> *ibid.*

altogether. It is in the interests of the economy and for the physical and mental wellbeing of carers, therefore, for the Government to produce a long-term strategy for carers.

This paper attempts to look at all these issues while setting out the main problems with the status quo, and considering the proposed solutions in the Wanless and Joseph Rowntree Foundation reports. It is hoped that it will provide the basis for a focused discussion on the merits and demerits of each model and on what a future vision of older people's care might look like. The main elements of such a vision should include:

- A funding model which provides good quality care for all older citizens in an equitable way
- A fairer system of utilising people's assets to pay for care
- Greater use of preventative services which may save on later costs of care
- Better integration of services to prevent gaps in care for older people
- User-centred services which enhance older people's dignity and empowerment.

Practical policy measures which stem from this might include:

- A new system of funding care which combines the elements of universality and private contribution
- A Sure Start for older people in every neighbourhood
- A dedicated independent care advice service for all older people, their families and carers
- A Government-supported equity release scheme to enable more people to access money to pay for care
- Employer-provided care vouchers to assist with the costs of care thereby enabling carers to stay in or return to work
- Reform of the continuing care criteria to make the system more equitable, particularly for older people with dementia.

The Wanless and JRF papers have put forward a number of costed and sensible options for reform. It is up to the Government and opposition parties to build on their suggestions in the window of opportunity before the 2007 CSR, to build a strategy for older people's funding and care in the next 10-20 years. This should be accompanied by an informed and wide-ranging national public debate to generate a consensus about how our older citizens' and their families' and carers' needs will be provided for in the future. This paper seeks to inform that important process.

## Chapter 1

# Key demographic and cultural changes over the next 20 years

Whether the current funding system is sustainable or not will mainly be determined by demographic changes, and the effect these will have on demand for care services. Projections conclude that there will be an increase in the number of older people which is expected to peak around 2025 when the 'baby-boomers' born after World War II reach their seventies and eighties. Baby-boomers make up around 29 per cent of the total population, or 17 million people.<sup>3</sup>

The following statistics illustrate the challenge we face:

### 1. An ageing population

The Government Actuary's Department has projected that the number of people aged 65 and over in the UK will increase by 81 per cent from 9.3 million in 2000 to 16.8 million in 2051.<sup>4</sup> The over 85s are projected to increase even faster from 1.1 million in 2000 to 4 million in 2051 - a growth of 255 per cent.<sup>5</sup> Life expectancy for men is projected to rise from 75.9 years in 2002 to 81 years in 2031. Women will live even longer with a projected rise from 80.5 years in 2002 to 84.9 years in 2031.<sup>6</sup>

### 2. Increase in disability

The number of disabled people is projected to increase by nearly 70 per cent between 2002 and 2031.<sup>7</sup> Analysis conducted by Jagger et al for the Wanless Review also pointed to an increase in disability and therefore an expansion of morbidity, but the evidence base is weak and so we cannot accurately predict disability trends for the future.

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<sup>3</sup> Census 2001

<sup>4</sup> As quoted in Raphael Wittenberg et al. (2004) *Future demand for long-term care in the UK – A summary of projections of long-term care finance for older people to 2051*, Joseph Rowntree Foundation

<sup>5</sup> *ibid.*

<sup>6</sup> *ibid.*

<sup>7</sup> PSSRU Bulletin Number 15

### 3. A fall in informal care

It is projected that while there will be an increase in care from spouses, there will also be a decrease in care from children in the future. This is because of predicted increases in female employment, a decline in the number of children living with their parents in old age, and increasing numbers of childless older people.<sup>8</sup> The number of single-person households is increasing and is expected to continue. For example, 41 per cent of people born in 1946-50 are forecast to be living alone by age 75 compared with 39 per cent of those born in the 1930s, suggesting that half of the baby-boomers may be living on their own by the time they reach 75.<sup>9</sup>

### 4. An increase in dementia

The steady increase of older people with dementia will also put pressures on long-term care funding. The Alzheimer's Society projects that by 2010 there will be about 870,000 people with dementia in the UK – a figure which is expected to rise to over 1.8 million people by 2050.<sup>10</sup> Other estimates suggest that in the years up to 2031, there will be a 66 per cent increase in the numbers of older people in England with cognitive impairment, and a 58 per cent increase in the number of people with functional impairment.<sup>11</sup>

### 5. Increased expectations

The level of demand for care may be influenced by the changing expectations of older people and their relatives both in regard to the level of, and quality of long-term care. It is difficult to quantify how such expectations may affect the costs of care, but it seems reasonable to assume that people who have become more used to a consumer-led society will be less willing to tolerate low quality levels of care. For

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<sup>8</sup> PSSRU Bulletin Number 15

<sup>9</sup> Evandrou and Falkingham, 'Looking back to look forward'

<sup>10</sup> [www.alzheimers.org.uk/News\\_and\\_Campaigns/Policy\\_Watch/demography.htm](http://www.alzheimers.org.uk/News_and_Campaigns/Policy_Watch/demography.htm)

<sup>11</sup> PSSRU (2003) *Cognitive Impairment in Older People: Its implications for future demand for services*. University of Kent.

example, there is some evidence that younger people are less satisfied with the health services they receive: 91 per cent of people over the age of 65 are satisfied with their GP, compared to 74 per cent of 25-34 year olds.”<sup>12</sup> As that younger generation grows older, we may see these attitudes affecting their impressions of other care services too.

The attitudes of the baby-boomers in older age are also likely to have an impact on the demand for care. A report by Demos in 2003<sup>13</sup> pointed to the individualism and liberalism of the baby-boomer generation. They are the first generation to have experienced commercialism and therefore the idea that they can expect to have their individual wants and needs satisfied. A survey by MORI, for example, found that 60.5 per cent of respondents claim that their trust in public services is influenced by whether they meet their needs.<sup>14</sup> Baby-boomers are also more educated than the older people who have gone before them. For example, 27.5 per cent of baby-boomer males and 24.5 per cent of females have a degree or equivalent. By contrast 24 per cent of males and 37 per cent of females in older generations have no qualifications at all.<sup>15</sup>

## 6. An increase in home ownership

Trends in home ownership will rise as the number of households is expected to increase from 20.9 million in 2003 to 25.7 million in 2026, a 23 per cent increase. Estimates suggest that one-person households would account for almost 70 per cent of this growth, of which 60 per cent would be individuals aged 55 and above.<sup>16</sup> If older people are encouraged to use their housing equity to pay for care there might be a rise in demand for care.

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<sup>12</sup> Quoted in DH *National Service Framework for Older People 2001*

<sup>13</sup> Julia Huber and Paul Skidmore, 2003, *The New Old – Why baby boomers won't be pensioned off*

<sup>14</sup> MORI, *Trust in Public Institutions*, 2003

<sup>15</sup> Julia Huber and Paul Skidmore, pg. 45, 2003, *The New Old – Why baby boomers won't be pensioned off*

<sup>16</sup> ODPM (2005) quoted in *Home Made Money: A co-production approach to equity release*, J. Kakkad, B.Gough, Social Market Foundation (2006)

## 7. The rise in the 'silver' vote

It could be argued that the Government itself is raising people's expectations of the level of quality of care they might receive in older age, by using the language of choice, dignity, independence and control in its Green Paper on Adult Social Care, and more recently in the Health and Social Care White Paper. While this approach is entirely laudable, rhetoric about the standards of care that older people should expect to receive must be matched with reality when they really need it. If not, the so-called 'silver vote' will brandish its electoral power to force politicians to find the money to provide the quality of services they have been promised. Research by Age Concern<sup>17</sup> which analysed the voting of older people at the last general election found that over 40 per cent of the votes were cast by the over 50s. By 2025 the report predicted that this figure would have risen to over 50 per cent of all votes cast. The research also projected that because of demographic trends, the Labour party could lose 10 seats at the next election even if the Conservatives did not make any headway. Older people are also less politically aligned than before with 1.8 million describing themselves as 'floating voters'.

Poor quality care was one of the key issues cited by older people interviewed for the research as a factor which might affect their voting intentions. It is not just older people voting en bloc, however, that politicians should take notice of; their families and carers are also likely to be affected by the experiences of older people receiving care, creating an even larger group of voters who could hold the key to winning or losing for a future government. As the number of older people grows in the future, therefore, so will the imperative on politicians to take their views into account.

A study for the JRF by Wittenberg et al (2004)<sup>18</sup> into the potential demand for long-term care projected that:

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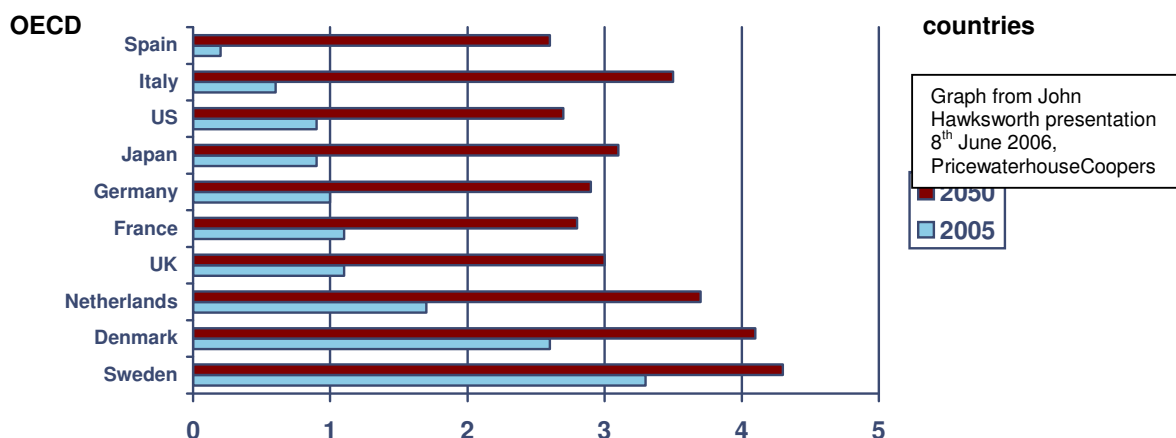
<sup>17</sup> *Winning in 2009: the importance of the baby boomers*, Age Concern, February 2006

<sup>18</sup> Raphael Wittenberg et al. (2004) *Future demand for long-term care in the UK – A summary of projections of long-term care finance for older people to 2051*, Joseph Rowntree Foundation

- Expenditure on long-term care will need to rise by around 317 per cent in real terms between 2000 and 2051 to cope with the demographic pressures outlined above and to keep up with rises in social and health care costs.
- Residential places will need to expand from around 450,000 in 2000 to 1,130 in 2051 (a 151 per cent increase).
- The number of care home hours would need to increase by 137 per cent from about 2 million per week in 2000 to over 4.8 million per week in 2051.

The need to increase spending quite dramatically is also mirrored across the world:

**International comparisons of public spending trends for long-term care in selected OECD countries**



Note: assuming historic cost trends continue (mitigating these might cut spending in 2050 by c.1 per cent of GDP)

Source: OECD (2006)

Despite the evidence for these demographic pressures, Treasury forecasts for increases in long-term care spending remain cautious. In its most recent projections, long-term care is projected to rise from 1.2 per cent of GDP now to nearly 2 per cent by 2054-55.<sup>19</sup> This could be compared to the Wanless review projections in Scenario 3 under which costs will increase to 2 per cent of GDP by 2026.

<sup>19</sup> *Long-term public finance report: an analysis of fiscal sustainability*, HM Treasury, (December 2005)

Of more immediate concern is the planned rise of just 0.1 per cent of GDP between 2004/05 and 2014/15 while during the same period the number of centenarians is expected to increase by 77 per cent, and the number of people over 85 to increase by 39 per cent.<sup>20</sup> The Wanless Review suggests that there should be an increase of 0.2 per cent of GDP by 2007. As the next section argues, increased funding is not just required for the long-term future, the current system is facing a crisis of underfunding. In light of this, the Treasury needs to rethink whether their forecasts are going to be sustainable for the change in demographics that the UK faces in the future and the need to cover gaps in care in the present.

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<sup>20</sup> Government Actuary Department, 2004 based principal projection quoted in: *Creating Security in Retirement*, Age Concern, (July 2006)

## Chapter 2

### Demonstrating unmet need

Unmet need is difficult to define and is therefore difficult to quantify. It can refer to inadequate provision of services needed, but it can also be a failure by older people and their carers to articulate or identify what their needs are. Often it is the assessment processes themselves which fail to identify needs. It is important to try to establish levels of unmet need, however, because it provides evidence of whether the current funding system is targeting resources at their optimal level.

The Wanless Review concluded that “there is evidence of significant unmet need”. Using General Household Survey data, the Wanless team found that services are successfully targeted on people with significant needs, but even then only a small proportion of those eligible are using those services. Those people who live in their own home and have low level needs are particularly poorly provided for. The number of older people in receipt of home care in England, for example, is low by international standards – only 4 per cent of those aged 65 or over receive formal help at home compared to 25 per cent in Denmark. Home care hours may have doubled between 1992 and 2004, but the number of households receiving such help has fallen in that time too. Services such as meals delivery have also been affected: the number of people receiving a meals service through their council, for example, fell from 147,271 to 129,000, despite an increase in the number of older people.<sup>21</sup>

Unmet need is generally thought to be prevalent in domiciliary care services, though a report by the Joseph Rowntree Foundation in 2001<sup>22</sup> raised a number of concerns about areas of current provision in care homes which neglect the needs of older people. It pinpointed the lack of diagnosis and treatment of depression of elderly people, citing that less than 2 per cent of staff working in residential and nursing homes had received any training in

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<sup>21</sup> [www.csci.org.uk/publications/national\\_reports/state\\_social\\_care\\_3.htm](http://www.csci.org.uk/publications/national_reports/state_social_care_3.htm)

<sup>22</sup> Lis Cordingley, Jane Hughes and David Challis, (2001), *Unmet need and older people – Towards a synthesis of user and provider views*, Joseph Rowntree Foundation

recognising depression. This is in spite of the fact that depression is a common and treatable condition amongst older people. The report also highlighted the lack of stimulation for older people in residential care even though studies have shown that activities within the home can prolong longevity.<sup>23</sup> Age Concern has argued that the provision of activities in some care homes are too often seen as ‘an added extra’, rather than being central to the well-being of residents.<sup>24</sup>

### *Underfunding in care homes*

One of the main reasons for a shortfall in the quality of residential care is because of underfunding. Research conducted by the Joseph Rowntree Foundation found that the care home sector was being under-funded by £1 billion a year.<sup>25</sup> An earlier study in 2002 found that the full cost of operating an efficient, good quality care home which meets all the national minimum standards is around £75-£85 more than the average fees paid by local authorities.<sup>26</sup> This is because fee increases paid by local authorities to providers have not kept pace with costs such as the introduction of the minimum wage and new standards, leading to a funding gap. Changes in 1996 to the capital limits which brought more people into the local authority funding ‘net’, the introduction of assessment for carers and the gradual withdrawal of the NHS from providing long-term nursing care, have all also increased pressures on funding without a concurrent increase in the funding allocation.<sup>27</sup> This has resulted in self-funders cross-subsidising the care of local authority supported residents. Not surprisingly those self-payers find this system increasingly unjust.

The shortfall in funding has created a ‘damaging preoccupation’ with containing costs rather than raising quality in the care home sector according to the King’s Fund. As a result, the sector is characterised by low pay, poor

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<sup>23</sup> Godlove Moszley, C., et al, (2000) *The Quality of life study: outcomes for older people in nursing and residential homes*, Unpublished report presented to the NHS Executive, DH

<sup>24</sup> *Care Homes and Long Term Care Needs*, Age Concern Statement, 2004

<sup>25</sup> *Calculating the Costs of Efficient Care Homes*, W.Laing, (2004), Joseph Rowntree Foundation

<sup>26</sup> *Calculating operating costs for care homes*, W.Laing, (2002), Joseph Rowntree Foundation

<sup>27</sup> *Nothing Personal, Rationing Social Care for Older People*, Help the Aged, 2002

recruitment and retention rates and a lack of training. Vacancy rates are higher in social care than in any other employment sector in the UK and staff are paid less per week than the average for all other professional occupations.<sup>28</sup> It is not surprising, therefore, that older people in care homes are often receiving sub-standard care which is failing to meet their needs. This is made all the more difficult as the proportion of older people with high dependency needs is increasing.

### *What are older people's needs?*

Older people's views about their needs can often conflict with a formal diagnosis of needs by social services. The JRF's Older People's Inquiry *That Bit of Help* showed that older people value things such as help with cleaning, DIY, gardening, care of pets, chiropody, transport and befriending to enable them to live fulfilling and independent lives within their own home. It is precisely these services, however, that have suffered as a result of the concentration of resources on people with high-dependency needs. The experience of Counsel and Care advisers bear this out:

Miss E contacted the Counsel and Care advice service asking for information about local support services which would be available to help her care for her mother. Her mother was 86 and was living in her own home, and had suffered a fall the previous week which had resulted in her being admitted to hospital with bruising and shock. Miss E did not live close to her mother and was unable to provide much support personally to her mother. She wanted to arrange local services to help her manage at home.

The advice worker was able to put Miss E in touch with several local home care agencies and an Age Concern branch which provided a 'handyperson' service. Neither Miss E nor her mother knew of these services before the accident, and there had previously been no contact with social services in their area.

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<sup>28</sup> £442.90 as compared to £617.30 per week in 2004 according to the Commission for Social Care Inspection: [www.csci.org.uk/publications/national\\_reports/state\\_social\\_care\\_3.htm](http://www.csci.org.uk/publications/national_reports/state_social_care_3.htm)

## Early intervention

Not only do older people value 'low level' interventions, there is some evidence that investing in such services could help to cut costs further down the line. Evidence from the former ODPM shows that reducing the amount of institutionalisation of older people by 1 per cent a year could save £3.8 billion.<sup>29</sup> Helping to prevent home accidents is one of the ways of achieving this. According to the ODPM: falls, burns and scalds in the over 65s age group costs the health service around £3bn a year and increases dependence on council and other services. A study of 12 local authorities quoted in the Wanless Review found that for every £1 spent on home care, the average costs of hospital care fell by 30p.<sup>30</sup> Using the principle of 'invest to save', therefore, could help to reduce expensive admissions to hospitals or residential care. The Social Exclusion Unit's report *A Sure Start for Older People* argued strongly for a shift towards preventative care – inverting the so-called 'triangle of care'. Using ELSA data the report suggested that people with better self-reported health were also those who participated more in society and had stronger social networks. The report went on to suggest pilots of the Sure Start model under the name of 'Link Age Plus' which are now underway.

The Department of Health's White Paper on Health and Social Care launched earlier in 2006 also argued that there should be an increased commitment to spending on preventative services. It makes logical sense that if ill health can be prevented or managed at an early stage, costly treatment and services may be required less at a later stage. The evidence base on cost-effectiveness, however, remains thin mainly because of the difficulty of attributing cause and effect. While there is much qualitative evidence on the immediate benefits of the interventions such as in *That Bit of Help*, there is less evidence to show whether such services delay deterioration or dependence on higher level services down the line. Further research and pilot studies need to be undertaken in this area, therefore, to provide a compelling

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<sup>29</sup> *Making life better for older people: An economic case for preventative services and activities*, ODPM

<sup>30</sup> *Securing Good Care for Older People*, Wanless Social Care Review, pg 61, (March 2006)

evidence base to back up the logic in the argument for the need for additional funding of preventative services.

Telecare is one growth area with strong evidence which shows that early investment can reap large rewards later in cost savings. By using the latest technology, telecare can enable older people to lead independent lives within their own homes, helping them to remain safe and can give their families and carers peace of mind. At the same time it can help to reduce admissions to hospital and the need for continual outpatient checks. Telecare has the ability to go much further than a community alarm service, it also has the potential to monitor vital signs (telemedicine) and allow older people with long-term conditions to remain at home. In West Lothian, which was one of the first councils to pilot the extensive use of non means-tested telecare, the average stay in a care home has decreased from three years to just 16 months. Around 3,200 hospital days are saved a year by getting people home quicker or preventing admissions.<sup>31</sup> The cost-savings are obvious – a basic telecare package costs £8,680 a year, compared with £21,000 to keep a person in a care home, and £46,600 for a long-term hospital bed. These financial savings are not isolated - the *Safe at Home* project conducted by Northamptonshire County Council estimated that they had made cost-savings of £1.5 million.<sup>32</sup> A similar story can be found in a telemedicine pilot run by Carlisle and District PCT for patients with Chronic Obstructive Pulmonary Disease (COPD). An evaluation of the pilot found that the average length of hospitalisation for this patient group has been reduced from 10 to five and a half days with a total saving of 990 bed days.<sup>33</sup>

The Government has recognised the value of telecare by launching the Preventative Technology Grant of £80 million in July 2005. This grant has been rolled out to local authorities since April 2006 and the ambition is for an additional 160,000 older people to be enabled to live at home through telecare. While this grant provides local authorities with a great opportunity to

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<sup>31</sup> <http://society.guardian.co.uk/longtermcare/story/0,,1746673,00.html>

<sup>32</sup> Tunstall Safe at Home Case Study (2005)

<sup>33</sup> *Telemedicine – the way forward in chronic disease management?*, DM Taylor RGN (Dip), for Tunstall and Carlisle Housing Association (2005)

invest in telecare for their communities, a number have failed to develop a local telecare strategy, delaying progress in these areas. Moreover since the grant was not ring-fenced some authorities have used the money to support other social care priorities. There is unlikely to be any further 'pump-priming' after 2007 so the success of the telecare roll-out will be dependent on some local authorities moving more swiftly or a commitment to continued funding through the 2007 Comprehensive Spending Review.

### *Poorly integrated services*

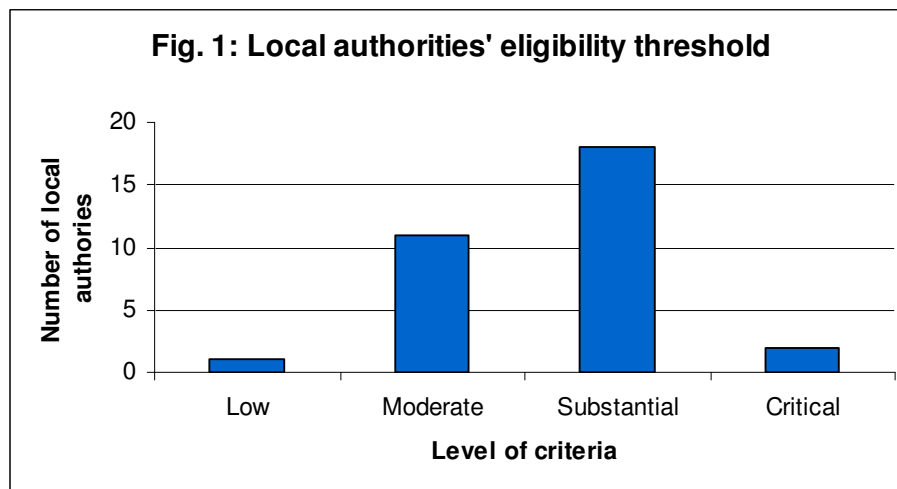
Despite the best efforts of central and local government policy-makers, many agencies involved in the support of older people do not work efficiently for the benefit of individuals. Agencies have a tendency to operate in silos and use systems which make it difficult to share information about service users, resulting in difficulties for those attempting to access services and arrange multi-agency support. Potentially, an older person could have contact with health agencies, social services, the benefits and pensions service, the housing department, and any number of community and voluntary services. In many cases these agencies do not cross-refer clients, so that someone who is potentially eligible for services from all of these sources is not captured by one agency and passed onto the others. The individual therefore either remains without support from these services, or they have to approach them all on an individual basis. This, of course, requires a certain level of knowledge that the other services are available, and that they are eligible for them.

There are examples of good practice where there are well-integrated local services, for example, where community nursing teams and social workers are based in the same office and implement the Single Assessment Process within multi-disciplinary teams. There are also improvements being made at Government level in relation to applying for particular benefits. For example, there is now a single application form for Pension Credit, Housing Benefit and Council Tax Benefit, which means that an individual who applies for one of these benefits is automatically registered for all three. Joint teams from the

Pensions Service and local social services who visit older people to help them with forms and applying for benefits are a good example of how services can integrate to provide a ‘whole-person’ approach.

### *The care services lottery*

A recent national survey by Counsel and Care of local authorities’ care charges and eligibility criteria identified a triple lottery for services: based on where someone lives; how their local authority applies the eligibility criteria for services; and the charging policy of the local authority.<sup>34</sup> The survey found that two-thirds of those authorities who responded now only offer support at the highest criteria levels of critical and substantial, neglecting hundreds of older people who have moderate or lower levels of need. The graph reproduced below reflects this:



Local authorities also appear to be tightening their eligibility criteria even further – one third of authorities interviewed had increased the threshold at which people were eligible for services in the past year. This contradicts guidance issued in 2003 by the Department of Health which stated that

<sup>34</sup> *Care Contradictions: higher charges and fewer services*, Counsel and Care, (September 2006)

councils should make efforts to identify individuals who currently have low level needs but which are likely to increase over time.<sup>35</sup>

There are also variations in what services local authorities charge for and how much they charge due to the discretion that central government allows authorities in designing their charging policies. Around 3 per cent of local authorities surveyed, for example, did not impose charges at all. Of those authorities which did charge, 39 per cent did not have a maximum weekly charge for their services. This can result in older people with the highest level of needs having to pay the highest costs. There is further variation in those authorities which do have a maximum weekly charge. The survey showed for example that the maximum can range from £3.91 per week to £315.90 per week – a huge difference and one which can have a negative impact on pensioner poverty considering that the average weekly income for pensioner households is £306.<sup>36</sup>

An older person living in one area may receive support from social services, but the same needs will not be met just a few miles away. This is perceived to be grossly unfair by older people who feel as though their access to care ought not to be determined by their postcode. Charging policies may put off older people on lower incomes from using services culminating in yet more unmet need. Local authorities appear to be blind to the affect their charges have on take-up of care – an Audit Commission report in 2000<sup>37</sup> found that despite guidance from the then Social Services Inspectorate that councils should monitor the impact of charges on the take-up of services, only 15 per cent of councils were able to provide a figure for the proportion of users who cut down on services following changes to charges. The government has sought to create greater consistency between charging policies with its guidance on fair access to services, but as Counsel and Care's recent survey shows, the inequity is continuing.

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<sup>35</sup> *Fair Access To Care Services: Guidance On Eligibility Criteria For Adult Social Care*, Department of Health (2003)

<sup>36</sup> *Care Contradictions: higher charges and fewer services*, Counsel and Care, (September 2006)

<sup>37</sup> *Charging With Care: How councils charge for home care*, Audit Commission (2000)

A counter argument could be made, however, which suggests that disparities between local authorities' charging policies is the natural outcome of 'localism' – a theory which is very much in vogue with all main political parties at the current time. Does this mean that older people's wishes to be able to access services equally, acts in opposition to the notion of localism? Is central government right to impose restrictions on the ability of local authorities to raise money through their statutory charging powers or does it just expose the reality of localism as pure rhetoric?

### *The continuing care gap*

The distinction between funding for health and social care has created arbitrary outcomes. For example, older people who qualify for continuing care funding from the NHS (such as cancer patients) have all of their costs covered, while people suffering from serious conditions such as Alzheimer's must pay for most of their costs because their need is not always considered to be primarily a health need. There is also concern that people who *are* entitled to receive continuing care have been assessed inappropriately, so that they do not receive the funding.<sup>38</sup> A further study concluded that nurses were under pressure to place care home residents on the middle band of nursing care to avoid having to assess whether the person might be eligible for continuing care funding.<sup>39</sup> A House of Commons Select Committee also condemned the 'postcode lottery' in access to continuing care, and suggested that the government must establish a national framework of eligibility criteria to resolve the situation.<sup>40</sup> This issue reached a head with the recent *Grogan* judgement<sup>41</sup> which reminds all Strategic Health Authorities and Primary Care Trusts to establish whether an individual has continuing care needs, and only after it has been determined that there are none may they then assess for the registered nursing care contribution.

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<sup>38</sup> NHS Funding for Long Term Care of Older and Disabled People, Health Service Ombudsman, 2003

<sup>39</sup> Olsen, R. and Regan, E. (2005) *Implementation of NHS-funded Nursing Care in Leicester, Leicestershire and Rutland*, Nuffield Community Care Studies Unit, University of Leicester

<sup>40</sup> House of Commons Health Committee, *NHS Continuing Care*, 6<sup>th</sup> Report of Session 2004-05

<sup>41</sup> R (Grogan) v. Bexley NHS Care Trust, 25<sup>th</sup> January 2006

The Government has recently consulted on a new national framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England. Given that the Government does not propose to change the legal basis for determining eligibility for care, however, it is likely that there will continue to be cases where access to continuing care is denied. Eligibility will still be based on an interpretation of the guidance and criteria. In particular the continued inclusion of 'unpredictability' of need as a criteria for assessing an individual's care needs makes it likely that people with high, but stable care needs, will continue to be ineligible for continuing care funding. This discriminates against people with dementia and mental health needs who may have continuing care funding withdrawn as their condition worsens. The abrupt withdrawal of funding leaves families and carers dismayed as they struggle to find extra money they did not anticipate. It is illogical that those people who the most severe or degenerative conditions are not eligible for continuing care funding.

There are also concerns that the success of the new framework will depend on carers, social workers, and care home managers making sure that eligible people are assessed for funding rather than RNCC nursing staff and hospital staff as is currently the case. Their lack of knowledge of the NHS and a paucity of training may stymie efforts to get funding to those who are eligible for it.

## Chapter 3

### Funding older people's care – where we go now

#### *Criteria for judging a funding system*

The criteria below can be found in most discussions about how long-term care funding systems should be judged. An ideal system would exhibit:

- *Fairness* both in the allocation of funding and in the way it is raised;
- Encourage personal and family *responsibility* both in the caring setting, but also in using private resources to pay for care;
- *Sustainability*, by responding to demographic, economic, and medical/technological pressures, and also be politically sustainable;
- Promote *dignity* and *independence* for older people;
- Encourage a higher *quality of care* while also providing efficiency;
- Provide an incentive for *preventative* forms of care.

Some people would argue that universality should be an explicit criterion for a fair funding system, though this might be at the cost of sustainability. Such discussions should be viewed in the context of the wider debate about the current operation and future of the welfare state. Are proponents of universality in funding for social care in practice arguing for a substantial extension of the welfare state? If so, how does this fit with recent political focus on creating diversity of provision and individual choice within services? The principle of redistribution could also be included as a way of judging whether a system is suitable, though it could be argued that the criterion of fairness covers this territory. Most importantly, these options ought to be placed before the public in a similar way to Turner's pension proposals so that there is an open and honest debate about the way forward.

A further criterion which is currently implicit in the way that funding is allocated is that of cost containment. It could be argued that this must be made explicit

if the general public are to fully understand the implications of the funding system for their future.

### *The current funding system*

The current system of funding for long-term care in the UK was introduced between 2001-02<sup>42</sup>. It followed a lengthy enquiry into long-term care funding by a Royal Commission set up by the newly elected Labour Government in 1997. The majority view of the Commission in its final report in 1999 was to provide both nursing *and* personal care<sup>43</sup> free to those who needed it. The recommendation to provide free personal care was not accepted by the Government on the grounds that such a move would increase demand, benefit wealthy older people and weaken incentives for individuals to make private provision. The Government did however accept the need to fund nursing care free to everyone regardless of income across the UK.

Since the 1948 National Assistance Act, primary responsibility for care provision has rested with local authorities. Also starting then, and continuing until today, was a division between *social* care for which fees could be levied, and *health* care provided free of charge<sup>44</sup>. Many of the problems encountered with the system of funding long-term care have been a result of this historic split<sup>45</sup> though recent Government legislation such as the Care Standards Act 2000 has sought to facilitate a more 'joined-up' approach between the two sectors.

Decisions about how much older people have to pay towards the costs of their care are made after a needs assessment and a decision by social services about the appropriate care package. If the individual has assets less than £12,500, only income is taken into account when assessing funding for care and the local authority will contribute extra money to uplift income if necessary

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<sup>42</sup> England introduced free nursing care in October 2001 and Scotland introduced free personal care in July 2002

<sup>43</sup> For example: feeding, dressing and personal hygiene.

<sup>44</sup> Though note exceptions such as prescription charges.

<sup>45</sup> The rise of 'bed-blocking' whereby older patients had to endure long stays in hospital while the Local Authority stalled in finding a care home place, is one example of this.

to the contract or tariff rate. All income must be used towards the costs of fees, except for an allowance of £19.60, which varies between UK territories, to spend on personal items. For individuals with assets over £12,500 and below £21,000, a tariff income contribution is required which can rise to £32 a week for those at the top of the threshold. People with assets over £21,000 are expected (with a few exceptions) to fund their own personal care and accommodation costs.<sup>46</sup>

Those above the assets threshold also still qualify for the Registered Nursing Care Contribution if they receive nursing care in a care home. This is paid through the NHS for "any services provided by a registered nurse involving the provision of care, or the planning, supervision or delegation of the provision of care, other than services which do not need to be provided by a registered nurse".<sup>47</sup>

Eligibility for NHS funded nursing care in England is divided into three bands according to need, which is determined after an assessment by an NHS nurse. The current levels of funding are: £133pw for complex nursing care needs, £83pw for standard nursing needs and £40pw for minimal nursing input, though Primary Care Trusts can increase this to £80pw on a case-by-case basis.<sup>48</sup> The high band is equivalent to approximately an hour and a half of a registered nurse's time per day in providing, planning, supervising and delegating care, according to the Department of Health.<sup>49</sup> The funding only covers nursing input to individual's care - not the overheads of running the care home. In 2003 there were 126,267 residents in care homes who were eligible for NHS funded nursing care.<sup>50</sup> If a person's primary need is assessed

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<sup>46</sup> The Royal Commission recommended an increase in the upper capital limit to £60,000.

<sup>47</sup> Section 49 of the Health and Social Care Act 2001

<sup>48</sup> The Department of Health announced that from 1 April 2006 RNCC bands would change as follows:

- the high band will increase from £129 to £133 per week

- the medium band will increase from £80 to £83 per week

the low band will remain at £40 per week with PCTs continuing to have the flexibility in deciding, on a case by case basis, to pay an amount between the low and medium band depending on need.

<sup>49</sup> 28<sup>th</sup> November 2005: [www.dh.gov.uk/assetRoot/04/12/56/49/04125649.pdf](http://www.dh.gov.uk/assetRoot/04/12/56/49/04125649.pdf)

<sup>50</sup> Department of Health *Census of Residents of Care Homes Receiving Nursing Care in England* November 2003

by their health authority as a health need then the NHS will cover all care costs through the Continuing Care Benefit.<sup>51</sup>

### *Scotland*

The key difference in Scotland is that since July 2002 local authorities no longer charge for personal care provided for people aged 65 and over living in their own homes. People aged 65 and over living in care homes, who would otherwise pay their own fees, also receive £145 a week towards personal care, and a further £65 if nursing care is required, from the Scottish Executive. This system has reduced the complexity inherent in the English system, but has created pressures on funding as described below.

### *Problems with the current system*

The current funding system suffers from a number of problems highlighted by both the Wanless and JRF reports. They are:

- i. The extent of unmet need as already highlighted in Chapter 1 means that current funding levels are already falling short of providing good quality care. Often self-payers in care homes find themselves subsidising local authority funded residents which leads to a sense of unfairness.
- ii. The system itself is complex and many people do not understand how it works. This can lead to people failing to claim for benefits or finding out how to get the best out of their finances.
- iii. People who save and those with modest assets are penalised because they have to cover most of the costs of their care without state support.
- iv. Means-testing is widely resented and the way in which costs and responsibilities are shared is perceived to be unfair. Many people do not realise that they might be liable for the costs of their care and are shocked and angry when they find they must use their assets to do so.

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<sup>51</sup> This was confirmed in the landmark Coughlan judgement in 1999

- v. The continuing care rules exclude some people with high dependency needs who feel that they ought to be eligible for state support e.g. some people with dementia.

To this it could be added that the current system does not focus resources on preventative services which could both increase the quality of care older people receive and help to cut future costs.<sup>52</sup> Moreover, a lack of commissioning expertise and failure to design services around the needs of the user means that value for money is not being achieved from current spending. There is a growing consensus that action is needed on these issues and that the status quo cannot continue.

Supporters of the current system would point to its concentration of finite resources on the most dependent and least well off individuals in society and the fact that a greater number of individuals privately contribute to their care compared to other funding options such as free personal care. But if Ivan Lewis's ambition for a service focused truly on the needs of the user and one which puts dignity at its heart is to be realised, the Government cannot continue to ignore the need for a new settlement on the funding of care.

### **Wanless**

The final report of the Wanless Social Care Review Team *Securing Good Care for Older People* grouped the criteria for judging funding models into five sections: fairness, economic efficiency, choice, physical resource development, clarity and sustainability/acceptability. The review concluded that a 'Partnership Model' came closest to satisfying the criteria established. The other two frontrunners included free personal care and a limited liability model. The following passage looks at all three.

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<sup>52</sup> See Chapter 9.5 *Securing Good Care for Older People*, Wanless Social Care Review (March 2006)

### *The partnership model*

This is the favoured model of the Wanless Review. It would guarantee older people a free of charge minimum amount of care set in the model developed by the Wanless team at 66 per cent of the total benchmark care package (though they left the option of varying this either up or down). Individuals would then be given the option of 'topping-up' their care package by making private contributions which would be matched pound-for-pound by the state until the maximum benchmark is reached. Once this maximum is reached state contributions will cease. People on low incomes would be helped to make their additional contributions through the benefits system.

The extra costs to the state would increase from £6.2 billion under the current means-testing system to £9.7 billion under the partnership model. Not all of this extra cost need necessarily come from new income sources, however, since Wanless proposed that two-thirds of the money spent on Attendance Allowance and Disability Living Allowance (care component) would be transferred to help pay the costs of people on lower incomes. This would leave a funding gap of £1.7 billion extra to find. Uptake of care would increase by around 45 per cent and total spending (including private spend) would total £13.7 billion. The state would contribute around 71 per cent of the costs of care, compared to 50 per cent currently.

The Wanless team gave a number of reasons why this was considered the optimum model for funding future care costs for older people:

- The model represents a better form of risk-sharing compared to the status quo because more people would be receiving more services.
- The system is fairer because it helps groups of older people who are neither very poor nor very rich unlike the current system which mainly concentrates resources on those poor people with high dependency needs.

- Fewer older people would have to 'spend-down' their assets which would mean that people who had made financial provision for their old age would not be penalised as they are in the current system.
- The system of charges will encourage people to feel more empowered by expressing choices within social care.
- The model removes the complexity inherent in any system which uses means-testing.

One of the main criticisms of the model is that scarce resources will be used to pay for older wealthier people who would have otherwise paid the total cost of their care under a new universal model. While the top-up will no doubt reward those people who have made financial arrangements for their old age, it is money that under the current system would be targeted on the poor. Critics argue that if older people have access to assets they should be expected to draw down on them to a reasonable extent. Not only is this more equitable, it is likely to increase the quality of care for those people as it can open up options which they may not otherwise have if they are simply relying on state support.

### *Free personal care*

This solution was recommended by the Royal Commission on long-term care and subsequently adopted in Scotland. Though there are variants on the model, essentially the state provides highly subsidised or zero charge care services out of tax revenue. Users are still liable, however, for hotel costs and a maximum limit can be set on the amount of free personal care an individual can receive to prevent people opting for the most expensive packages. There are a number of reasons why this system might be attractive according to Wanless:

- It scores well on aspects of fairness because provision is mainly based on need rather than ability to pay.

- Fewer people will have to run down their assets to pay for care and it does not penalise people who have made financial provision for themselves in old age.
- Scrapping the means-test will protect people's dignity.
- Free personal care has the best risk-pooling benefits of all the models examined.
- The system is less complex because it avoids means-testing.

The main criticism of this system is that it is financially unsustainable. Supporters point to a recent study<sup>53</sup> conducted into the Scottish experience which concluded that the fears about escalating costs were unfounded. The authors also concluded, however, that even though the system of free personal care in Scotland is not providing much financial pressure at the moment, demographic change and real cost rises of 2 per cent a year will cause these costs to triple by 2053.

### *Limited liability*

In this model the state could guarantee to fund a person's care costs after the lapse of a certain period of time receiving care (e.g. three years) or amount of expenditure on care (e.g. £20,000). The benefits of this system were listed as follows:

- It can help to protect people from eroding all their assets if the period of needing care is longer than expected or if they have higher dependency needs than expected.
- It rewards those people who have made financial provision for themselves in older age.
- Retaining the means-testing element will help to target money on the poorest people.

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<sup>53</sup> Bell D., & Bowes A., (2006) *Financial care models in Scotland and the UK – A review of the introduction of free personal care for older people in Scotland*, Joseph Rowntree Foundation

The main criticism of this model is that it does little to give extra help to the poor and it mainly benefits those who wish to retain some of their assets.

### *Joseph Rowntree Foundation*

The Joseph Rowntree Foundation's report *Paying for Long-Term Care: Moving Forward* presented five solutions designed to be piecemeal changes to the current system rather than root and branch reform. They included:

- i. Piloting a voluntary Equity Release Scheme for home-based care to enable home-owners to access capital tied up in their homes. Care charges plus a modest interest would be repaid when the person eventually sells their home. The cost of this change was estimated at £100 million a year depending on take-up, though the long-term costs would work out at a fraction of this as the loans are repaid.
- ii. Doubling the capital threshold for care home support which is currently £21,000 to £42,000. At the moment anyone going into a care home with assets above £21,000 will not receive any help with their funding from the local authority. Raising the limit would help prevent homeowners from having to use up all the value of their properties before they could access state support. The cost to the state of this change was estimated at about £250-300 million a year.
- iii. Doubling the personal expenses allowance for people supported by local authorities in care homes. Presently poorer older people must give up almost all of their pensions to pay for care in care homes. They are allowed to retain £19.60 as a 'personal expenses allowance'. The JRF report proposed increasing this to £39.20 at a cost of around £250 million a year.
- iv. Charging all care home residents for non-care costs (food and accommodation). The proceeds (around £180 million) could be used to subsidise personal care.

- v. Reviewing the basis of Attendance Allowance to see whether it should either be turned into a 'care allowance' or whether it should be means-tested/taxed.

All of these solutions (except iv of the JRF proposals) will require the Government to increase spending on long-term care. The JRF proposals relative to Wanless's partnership model are financially more attractive, but their report was keen to stress that the options were not an alternative to fundamental reform of the system, merely a step towards it.

## Chapter 4

### A future vision for older people's care and support

A future vision for older people's care in 10 to 20 years time should be based on the assumption that older people, their families and carers deserve to have access to high quality advice and care within their local communities that is well-funded and sustainable. The current system is patchy, inequitable and costly. A future service should be comprehensive and seen to be fair and affordable. There also should be a strong aim to ensure that services provide better value for money than is currently the case. Within this remit, the following section outlines suggestions for reform.

#### 1. A fairer funding system

The Wanless Review provides an excellent analysis of future demand for care and the merits of different funding options. In time a consensus could be generated around the Partnership Model as a way of funding the future care of older people. In the current climate, however, the emphasis should be placed on getting better value for money out of the current spend of around £16.8bn on older people<sup>54</sup> and campaigning for incremental changes which will help to alleviate some of the frustration and unfairness experienced by many older people. Steps along this route could include:

- Adopting the Joseph Rowntree Foundation (JRF) proposal to increase the capital threshold for care home support to £42,000. Given that the average annual cost of a care home amounts to around £20,000<sup>55</sup> and the average length of stay in residential care is around three years, it seems unfair that someone with assets of just over £21,000 could spend down that total within the space of 12 months and still need to rely on state support thereafter. Increasing the capital threshold would also be a

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<sup>54</sup> *The Age Agenda 2006: Public policy and older people*, Age Concern, March 2006

<sup>55</sup> Office of Fair Trading, 2005

necessary *quid pro quo* of any push by Government to encourage people to use their housing equity to pay for care as described in section 6 below.

- Adopting the JRF proposal to double the personal expenses allowance for people supported by local authorities in care homes. This would support the Government's objectives of ensuring dignity for people as they age and giving older people more independence, particularly financially.
- Introducing minimum levels of care which must be funded by local authorities responsible for those people who are not self-funders. This will help to overcome the current situation whereby local authorities use eligibility criteria to exclude people with low level needs from state funding. This will require an increase in funding to social services budgets, but this could be offset in part by money saved through fewer people developing high dependency needs because of a lack of early intervention and support. Such a move, however, would need to be supported by increased evidence about the cost-effectiveness of interventions for older people with low to medium needs. In the short term the Government should issue stronger guidance to local authorities to encourage them to consider provision for lower level needs and preventative services and link this to the new Quality Ratings currently being devised by the Commission for Social Care Inspection. Greater emphasis on user feedback as part of the performance assessment could also help to ensure that all levels of need are taken into consideration, rather than just those people who have critical needs.
- Alongside the introduction of minimum levels of care, the government could consider the establishment of a tariff range for particular services in social care in a similar way to the NHS so

that users find it easier to judge whether a service is providing value for money. This could also help to even out the postcode lottery of care charges.

- Ensuring a new national policy framework for continuing care provides funding for people with the same level of needs but who live in different areas. In particular the priority level for cognitive impairment within the new proposed decision support toolkit continues to discriminate against people with dementia, for example, by making the balance of decision factors lean toward physical healthcare problems, rather than considering mental and physical problems equally. Moreover, the success of the Department of Health's proposed policy framework depends on individual health and social care professionals being made aware of the existence of continuing care and nursing care funding and ensuring that an individual is referred for the necessary assessments in relation to this. Training will therefore be a key element in ensuring this does not become a problem, and there is a need for a wider range of staff to have a working knowledge of healthcare funding, and who is eligible to receive it. Reducing the number of assessments patients and care home residents receive is positive, but it does mean that the burden of responsibility for making sure that eligible people are assessed for funding passes from RNCC nursing staff and hospital staff, to carers, social workers, and care home managers. Ensuring that some form of independent advocacy and information accompanies older people every step of the way through the care system would help to let them know their rights and fight for funding if eligible.
- Removing means-testing for access to Disabled Facilities Grants (DFG) for older people up to a maximum of £1,000. This would follow the recent decision not to means-test access to the

DFG for disabled children under 19. Continuing to means-test the DFG for older people, while children under 19 can access life-enhancing essential adaptations for free, amounts to age discrimination. A universal entitlement for everyone needing essential adaptations to their home up to a limit (at which point their income would be assessed) would remove the current anomalous exception for those under 19 and could help save costs further down the line particularly in relation to falls.

- Continuing the Preventative Technology Grant beyond 2008 to ensure that local authorities comprehensively support telecare packages for older people.

## **2. Information, advice and advocacy for every older person, their families and their carers**

In Counsel and Care's experience, the majority of social care users, or their families and carers, complain about a lack of information. Individuals are often charged with arranging a care home placement, for example, without the adequate support or information necessary to make a decision. For those outside the social care system, there is a lack of awareness of the type of support that social services can provide and arrange. The following case study from Counsel and Care's advice service is an example of this:

Mr P contacted the advice service after he had been informed by hospital staff that his 88 year old father needed to move into a care home instead of living on his own in his sheltered housing flat. The social worker involved simply told him that his father would be discharged in five days, and that he would need to have arranged a care home in this time.

Mr P was concerned because he didn't know where to start or what to consider. The advice worker took him carefully through the process of finding and funding a care home placement, informing him what social services had a duty to provide, and the responsibility of the hospital before his father was discharged. They talked about the necessity of a written care plan which outlined his father's needs, so that he knew what services he was looking for in a care home, how care homes were funded, and the circumstances in which support would be provided by the local council.

In the future all older people and their families or carers should have local access to an independent care adviser who works with them to secure the appropriate care package for their needs. The concept of independent advisers already forms a key part of the Government's agenda for choice in schools and healthcare. Care advisers could help to enhance older people's choice and independence by explaining all their care and funding options. This would be a contrast to the 'one size fits all approach' often adopted by social services. Such a service could also impact on local authorities' value for money requirements by better matching older people's needs to service provision. Advice about sheltered housing options or home care packages for example, could ensure that residential care is only used when really necessary. Such services could be provided by the voluntary and independent sectors, but should not be provided by social services themselves who have a vested interest in the financial implications of the advice given. The voluntary sector has a strong track record of providing comprehensive and trusted advice to older people, their families and carers, and would be well placed to take on this challenge.

According to the Office of Fair Trading, the provision of information by local authorities about care homes was patchy and inconsistent and only 27 per cent of self-funders had received information about care homes in their Local

Authority.<sup>56</sup> This led the OFT to suggest a national gateway for care home information so that older people and their carers were able to make an informed choice. This idea should be taken further to cover all care options since simply presenting the option of care homes may be misleading. The principle of a single gateway to advice and information, however, is a sensible one and should be considered in more detail by the government.

Further measures to enhance people's access to high quality advice and support might include:

- The development of independent advocacy in every neighbourhood, delivered through Sure Start for Older People projects and supporting choice through Direct Payments and eventually, Individual Budgets. Independent advice and advocacy will be the key to ensuring that older people are able to take advantage of the Government's drive to enhance their choice and independence. This will be particularly important for socially excluded older people who may feel less able to articulate their choices or who may find negotiating with figures of authority intimidating. Ensuring that all older people can access services no matter what their socio-economic background should be paramount in the roll-out of the choice agenda to guard against deepening the inequalities that already exist between groups of older people within society.
- The development of a *Good Care Guide* for older people, their families and carers. Obviously such a guide would be much more complex than the *Good Food Guide* equivalent but it could help to clearly set out options for funding care; different care settings; the performance of social services across all English local authorities; latest independent sector care home inspections; rights to continuing care and other benefits; and details of where older people and their carers could seek further advice. A similar idea is currently being put into practice to

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<sup>56</sup> *Care Homes for Older People in the UK: a market report*, Office of Fair Trading, (May 2005)

enable the roll-out of *Choose and Book*, the Government's plans to give patient's choice of hospital. Information will be made available to patients both at a national level through the NHS website, and local PCTs are also required to provide information to enable patients to make an informed choice. In a recent pamphlet, Paul Corrigan, special adviser on health at 10 Downing Street, has taken this idea further and suggested that the public be given information about the services offered and quality of primary care providers.<sup>57</sup> It makes sense that if older people, their families and carers are going to also benefit from the language of choice, they will need to arm themselves with information about different services and their options in order to exercise their choices effectively.

- The development of an independent website which older people could contribute their experiences of care services, both good and bad, akin to a new site which enables users of the NHS to log their impressions of the service they received: [www.patientopinion.org](http://www.patientopinion.org) In time this could provide a useful user-led information tool for people wishing to know more about how others rate particular services in local authorities or care homes. Such a system could also help to facilitate choice and to expose poor quality providers.

### 3. Making it easier for carers to care

The system of older people's care would break down if it was not for the work of informal carers. In 2000 there were around 5.8 million carers in England, between 3.4 million and 4 million of whom were providing care to people aged 65 and over. Often it is older people themselves doing the caring - one in six people over the age of 65 were providing some form of care.<sup>58</sup> A future system would afford greater support to carers in recognition of the huge benefit they give to society. New measures to help carers might include:

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<sup>57</sup> Paul Corrigan, *Registering choice: how primary care should change to meet patient needs*, Social Market Foundation, (2005)

<sup>58</sup> *Securing Good Care for Older People*, Wanless Social Care Review, (March 2006)

- The introduction of tax-exempt employer provided care vouchers which would work similarly to childcare vouchers and would extend to all carers. Care vouchers would help carers to balance their work and caring responsibilities by buying extra care when needed. An employee could select the most appropriate support from a range of accredited and approved services. Examples of such services might include: informal support and assistance with services such as cleaning and home maintenance; domiciliary services such as help with getting up, getting dressed, personal hygiene, shopping and walking etc.

Currently around 3 million working age people juggle paid employment with care and about 4 million people with caring responsibilities are of working age.<sup>59</sup> According to the Equal Opportunities Commission one in five carers has given up work to care.<sup>60</sup> Ensuring that carers remain in work will also be important to maintain a healthy ratio between working people and those receiving state funded care. It has been calculated that such vouchers could increase the amount of money going towards care by almost half a billion pounds per year.<sup>61</sup> This would give an incentive to carers to encourage them to care for older people in the future without forsaking their employment. In the future employers are going to have to increasingly rely on older workers many of whom will have caring responsibilities. A system of care vouchers could help employers to recruit and retain these workers in the spirit of the new age discrimination legislation.

- Enabling pensioners to claim carer's allowance. At the moment people who claim carer's allowance become ineligible once they reach pensionable age. It is argued that this is because the allowance is to replace lost income and once a carer receives a state pension this

<sup>59</sup> *A New Deal for Welfare: Empowering People to Work - Carers UK's response to the consultation*, (April 2006)

<sup>60</sup> *ibid.*

<sup>61</sup> Care Vouchers:- Involving Employers In Care Funding, Presentation by Lynne Curren, Accor Services UK, to All Party Parliamentary Housing, Care and Support Group, Summer Parliamentary Seminar and Reception, 28 June 2006

takes the place of income instead. If we are going to adequately reward carers, however, it seems churlish to take away the one recognition the state gives to carers that they are performing a vital public service. According to Stephen Byers in a recent lecture for Counsel and Care, the net cost of providing carer's allowance to pensioners would be £145 million. Such an amount could be taken from unclaimed council tax rebate and pension credits which amounts to around £2.5 billion.<sup>62</sup>

- A carers' emergency scheme in every local authority, as argued by Carers UK. All local authorities are required to have emergency plans for carers, but not all actually provide emergency back-up support for carers. Carers UK have found that carers often do not know who to contact to sort out alternative care; social services take too long to respond and replacement care services are often not available in an emergency. Since many carers are themselves older people they may find themselves suffering from illness but often have no other option but to continue caring through it, or face a stressful time trying to arrange other informal care from neighbours or relatives. Carers UK found 96 per cent of carers worried about what would happen in an emergency and this led them to avoid situations which would prevent them from being with the person they cared for such as going shopping or visiting friends – situations which most people take for granted. Despite the fact that every carer has a right to an assessment and as part of that an emergency plan, in practice only one in three carers had received an assessment and only three out of five covered emergencies.<sup>63</sup>
- In tandem with this there should be better respite provision for carers of older people. Caring can be both physically and emotionally draining and many carers suffer from ill health. According to a research report prepared for Carers UK, men and women who provide more care - 20 or more hours per week – are more likely to have long-term health

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<sup>62</sup> Stephen Byers MP, Counsel and Care Graham Lecture, 7<sup>th</sup> September 2006

<sup>63</sup> *Back me up: supporting carers when they need it most*, Carers UK, (January 2005)

problems, compared with men and women of a similar age who are not carers, especially at ages 60-74.<sup>64</sup> According to a recent report by Mencap, 7 out of 10 families have come close to, or reached, breaking point because of a continuing lack of short break provision by local authorities and trusts and 1 out of 3 of families have experienced a cut in their short break services in the last year.<sup>65</sup> The Government's commitment in its Health and Social Care White Paper to providing short-term, home-based respite support is to be welcomed, but given that many people have to pay for respite care because it is means-tested, many carers may feel bad about asking the person they are caring for to pay for their respite, particularly when they are vulnerable or are already paying charges for other aspects of care. Given that many carers are performing a vital social role it seems unfair that the state does not offer them the option of funded respite care particularly when they are at breaking point. A minimum level of state funded respite for all carers should be considered by the Government regardless of the income of the person being cared for.

- Increasing carer's allowance to at least the same level as the minimum wage. Many carers feel that their contribution to society is not adequately valued through the benefits system. Raising carer's allowance to at least the minimum wage could help to finally give carers the recognition they deserve. Some carers have caring responsibilities which may mean it may be impractical for them to work as well. Such carers would be unable to benefit from care vouchers as advocated above, but an increase in carer's allowance combined with improved opportunities for respite could compensate for that. In general the Government should look at the whole system of benefits for carers, particularly those on Incapacity Benefit, to simplify and streamline the process of receiving support for the work they perform.

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<sup>64</sup> *Older Carers in the UK*, Sheffield Halam University, (November 2005)

<sup>65</sup> *Breaking Point – families still need a break*, Mencap, (September 2006)

- The Government's announcement last year that the right to flexible working will be extended to all carers is to be welcomed. Definitions of exactly which carers will qualify however, are yet to be decided, and it is imperative that the restrictions are not drawn too narrowly when the Work and Families Act comes into force in April 2007. At the moment it is likely that those carers at work caring for near relatives, partners, and people living with them would qualify, but not a neighbour or a friend caring for an older person, for example. Given increasing mobility in society it is more likely than ever that your carer may not be a member of your family, but the Act does not recognise this. A restrictive definition could further mean that an aunt or uncle who cared for you may not be eligible for flexible work under the Act. A definition which restricted requesting flexible working for only an immediate relative would exclude 400,000 working carers from being eligible to request flexible working.<sup>66</sup> Limiting the definition in this way will also increase the complexity of interpreting who is eligible and may lead to employees failing to enforce their rights as well as employers facing more tribunals as people try and test the definition. It is also likely to limit the benefit to businesses of retaining carers as employees.

#### 4. A stronger focus on improving service quality

While standards have been improving in the adult social care sector, many concerns remain. The social care inspectorate, the Commission for Social Care Inspection (CSCI), has reported inadequate protection policies and health and safety procedures as an area which still needs substantial improvement.<sup>67</sup> Moreover, around 20 per cent of residential providers and 30 per cent of domiciliary care agencies do not meet the general standards demanded by the inspectorate and most services still fail some of the minimum standards.<sup>68</sup> For example, a CSCI report in early 2006 found that

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<sup>66</sup> 'ASDA call on government to act for carers' Press release, 25<sup>th</sup> September 2006  
[www.carersuk.org/Newsandcampaigns/makeWORKwork/Latestnews/1159285039](http://www.carersuk.org/Newsandcampaigns/makeWORKwork/Latestnews/1159285039)

<sup>67</sup> Commission for Social Care Inspection:  
[www.csci.org.uk/publications/national\\_reports/state\\_social\\_care\\_4.htm#2](http://www.csci.org.uk/publications/national_reports/state_social_care_4.htm#2)

<sup>68</sup> *ibid.*

nearly half of England's nursing and care homes fail to meet minimum medication standards.<sup>69</sup> CSCI's recent report on the quality of home care provision also highlights concerns around quality of provision.<sup>70</sup> The Commission suggested that the home care sector has the characteristics of a 'cottage industry' with many small, inexperienced providers and there is substantial churn in the market. While older people tend to express high levels of satisfaction overall with home care services, they also expressed concern that visits were often rushed and care workers were often late and therefore unreliable. The '15 minute slot' mentality has resulted in care workers finding it difficult to fulfil older people's care plans in the time available. Moreover, there is evidence that many agencies which hire care workers 'cut corners' in their selection and recruitment practices potentially putting older people at risk. The Department of Health's review of the National Minimum Standards for Domiciliary Care will provide an important opportunity to refocus commissioners' thinking away from inputs and onto the outcomes older people wish for themselves.

It is imperative that a vision for social care puts increasing service quality at its heart and at the same time delivering value for money in the services that are provided. More pressure should be placed on local authorities to take a strategic approach to commissioning services to provide not just value for money for taxpayers, but also value for *self-payers'* money. The Wanless Review argued that any extra funding for social care from the Government must be matched by 'a commitment to reconfigure services' and in particular a step change in the way services are commissioned. Commissioners should ensure that they are focusing on the needs of all service users in the community, not just those they fund. From 2007 the Commission for Social Care Inspection will be including the effectiveness of commissioning and purchasing as part of the Annual Performance Assessment which will help to drive up standards. At the moment, as CSCI has pointed out, commissioning

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<sup>69</sup> *Handled with care? Managing medication for residents of care homes and children's homes – a follow up study*, Commission for Social Care Inspection February 2006

<sup>70</sup> *Time to Care? An overview of home care services for older people in England, 2006*, Commission for Social Care Inspection, October 2006

is too focused on inputs and outputs rather than outcomes.<sup>71</sup> This needs to change so that the views and aspirations of service users are fully embedded in the way that services are commissioned. This will help to generate greater efficiency as services are better matched to people's needs as well as contributing to user-empowerment and the creation of greater choice in service provision. At the moment there is still too much of a 'provider' culture, rather than promoting independence for service users. Requiring local authorities to focus much more on 'personalised' services will help to provide a fairer system of provision for payers and non-payers.

## 5. Sure Start for Older People

As with Sure Start for children, older people should have access to local services which offer interventions to prevent social exclusion and which provide ongoing services tailored to their needs. The Social Exclusion Unit's report earlier this year<sup>72</sup> which argued that the principles behind Sure Start for children and families should be extended to local services for older people, is to be welcomed. Older people often find themselves pushed from pillar to post in their search for services. A Sure Start for older people in every neighbourhood could act as a hub, building on best practice that is already currently available, giving access to a number of healthcare, social care, educational and activity services. In particular the notion of 'active ageing' is a good one, and more should be provided for older people to enhance their mental as well as physical well-being. Services could range from personal care, telecare and home repairs to better information about local leisure and employment opportunities. This could be provided through a local centre and also through out-reach services, building on existing community resources and facilities such as sheltered or extra care housing, care homes or the growing number of children's centres promoting intergenerational services.

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<sup>71</sup> *Relentless optimism: creative commissioning for personalised care*, Commission for Social Care Inspection, September 2006

<sup>72</sup> *A Sure Start to Later Life: ending inequalities for older people*, Social Exclusion Unit, 2006

The Government's plans for Link-Age Plus pilots are a step in the right direction and may help to provide the evidence for the cost-effectiveness of a Sure Start model for older people. As previously argued, early interventions and preventative services could help to save on later costs of care, but there is too little research data to date to form the basis for a substantial new programme of care services. Link-Age Plus pilots may help to overcome this evidence deficit and form the basis of a Sure Start for older people nationwide. Partnerships for Older People Projects and Local Area Agreements will also help to provide case studies of best practice in this area.

## **6. Help to use private assets to fund care**

A recent Social Market Foundation publication has argued that the state should play a role in 'co-producing' equity release products to make them more affordable for older people who could use the equity in their house to fund care, or make alterations to their home to enable them to remain within it.<sup>73</sup> At the moment the equity release market is small and the high charges associated with it put off older people. An extra barrier is the general perception of financial products being too risky. The SMF report recommends that equity release products should be accompanied with compulsory 'product-specific' advice to help to generate confidence in the product and ensure that consumers are better protected.

Long-Term Care Insurance products may also have a role to play. The market for LTCI products in the past has been small and most major LTCI providers such as Norwich Union and BUPA withdrew their products in 2004. One of the main reasons for the lack of take-up was because of the high cost of the policies. Insurers were taking on high risks because of the uncertainty of the costs of future care and the length of time care might be needed. A new funding settlement which more clearly identified individuals' obligations such as the partnership model, could help to bring down the risks associated with LTCI for the insurer, thereby lowering the costs of premiums.

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<sup>73</sup> *Home Made Money: A co-production approach to equity release*, J.Kakkad & B.Gough, Social Market Foundation, 2006

Proposals to encourage people to take out financial products to help them pay for care could include:

- The development of a single national assessment instrument. This would ensure equity of access to appropriate levels of care and support for all and could also mesh with Long-Term Care Insurance products or other private funding methods. Such a system would have the ability to determine the amount of funding a person would require to cover their care as well as their care needs which would lead to a much more streamlined system than currently exists. Using a common assessment tool for care across the state and private sectors could help to make the system fairer in the eyes of users, and also encourage a whole person approach when assessing care needs, rather than one based on funding streams as is currently the case. Commissioning of care is about resource allocation while planning care is about meeting assessed needs. Having a common root, therefore, would enable a clear linkage between commissioning and provision. Furthermore the ability to build up data through repeated assessments may provide an individual, person-centred profile of outcomes, providing indicators of the quality of care received. Such a system could help to widen the focus away from costs and onto needs, quality of provision and outcomes for older people.<sup>74</sup>
- Ensuring that older people who use modest amounts of equity release to pay for care or home adjustments do not lose out on other means-tested benefits as recommended by a recent report by the Joseph Rowntree Foundation.<sup>75</sup>
- Developing equity release products through a funding company sponsored by local government. Such a company could also offer non-commercial loans on behalf of and funded by the local authority. This

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<sup>74</sup> [www.jrf.org.uk/housingandcare/mds/default.asp](http://www.jrf.org.uk/housingandcare/mds/default.asp)

<sup>75</sup> Rachel Terry and Richard Gibson, *Obstacles to Equity Release*, October 2006

could help people who would like to release small amounts of equity from their property, but cannot do so commercially because of the type of housing they are living in e.g. former council housing.<sup>76</sup>

## 7. Increased financial control and empowerment

Evidence from the Counsel and Care advice service confirms that older people often feel they have lost their dignity as a result of needing care. A move into a care home can result in a degree of loss of control over personal affairs, such as when to eat meals, and very often family or carers assume responsibility for finances. For someone who has been living a reasonably independent life before such a move, this can be difficult. Other examples include those older people who remain living in their own home, but who receive support from care workers and family members. Agency staff often visit at the particular time which suits their daily schedule, leaving the older person with little option but to accept the service when it is delivered, rather than when it is required. A future model of care would ensure that older people are at the centre of the service, rather than a mere recipient. As the Commission for Social Care Inspection puts it: *“Future models for planning and delivering services must ensure that older people can choose what kind of help they receive, when they receive it, and who provides it. This implies a profound cultural shift – towards thinking of the individual as the ‘customer’ rather than leaving the purchasing power with councils. In many cases it will also involve the actual transfer of budgets to older people so they can purchase their own support.”*<sup>77</sup>

The Government’s Direct Payments scheme has been one way of increasing older people’s control over what care and support they receive, and after a slow take-up, more and more people are feeling comfortable with using Direct Payments. According to the Department of Health, the number of adults receiving Direct Payments increased from 9,000 in 2002/03 to 24,500 in

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<sup>76</sup> For more information see *ibid.*

<sup>77</sup> *Time to Care? An overview of home care services for older people in England, 2006*, Commission for Social Care Inspection, October 2006

2004/05.<sup>78</sup> A recent CSCI report found that only 7,000 older people were using Direct Payments to purchase home care in 2004/05 compared with more than 300,000 receiving state-funded home care.<sup>79</sup> This number is likely to increase now that the Government has required local authorities to give people Direct Payments where they can consent to them. Problems may occur, however, if those who can consent to Direct Payments is defined in a narrow way, excluding many older people who would benefit from such payments, but would require extra support to enable them to do so. There is also some evidence that cultural barriers may prevent take-up of Direct Payments as some social care advisers may automatically presume that service users are incapable or unwilling to consider such payments. There may also be a feeling of a loss of control on behalf of the social care worker who until now may have been responsible for taking decisions on an older person's behalf. Some social care workers may feel that Direct Payments challenge their professional judgement,<sup>80</sup> others lack basic literacy and numeracy skills which prevent them from giving older people the optimum level of help.<sup>81</sup>

Many older people would benefit from the option of using Direct Payments, but their choices are being narrowed unnecessarily. Local authorities should ensure that all older people, their families and carers who are entitled to use Direct Payments are told about their rights and provided with both information and advocacy if necessary. The Government's recent review of the social care workforce *Options for Excellence* presents a prime opportunity to ensure that all social care workers have the training and capacity to give appropriate advice and support to older people, their families and carers on Direct Payments, and in time, Individual Budgets, which is discussed next. Ideas included in *Options for Excellence* such as a Charter for Continuing Professional Development for all social care staff; better support for newly

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<sup>78</sup> *Our Health, Our Care, Our Say*, Department of Health, 2006

<sup>79</sup> *Time to Care? An overview of home care services for older people in England, 2006*, Commission for Social Care Inspection, October 2006

<sup>80</sup> *Direct Payments: what are the barriers?*, Commission for Social Care Inspection, 2004

<sup>81</sup> *Options for Excellence – Building the Social Care Workforce of the Future*, Department of Health and Department for Education and Skills, October 2006, pg 13

qualified social care professionals; and the integration of views and experiences of service users into workforce training are to be welcomed, but as the report itself states, many of these proposals will be dependent on new funding being made available through the Comprehensive Spending Review in 2007.

The idea of financial empowerment is being taken further forward by the Government's pilot of Individual Budgets. Individual Budgets combine different streams of funding, not just from the local authority, to further increase the control social care users have to manage their support and choose the services that suit them best. While the initial results from the pilots seem positive, one barrier to the effective operation of Individual Budgets is a lack of local NHS funding streams to supplement local authority finance because of the recent funding pressures in that sector. For Individual Budgets to work effectively, however, there needs to be proper integration of budgets to adequately reflect a user's potential multiple needs. Moreover, Individual Budgets will suffer similar problems to Direct Payments if older people, their families and carers are not offered enough information and advocacy to help them to realise their entitlements.

## **8. Better and more housing options**

As our society gets older, and more people live on their own, the pressure on housing is going to increase. Too much of current housing stock for older people is in poor condition and contributes to their decline in health and social exclusion. At the moment there is still too much focus on housing provision for groups other than older people in society. Housing targets do not focus enough on outcomes which affect quality of life such as access to green space, affordable warmth, or security. There also needs to be a greater focus on improving the quality of care homes so that they are able to provide a genuine choice for older people. Without a comprehensive strategy for the delivery of older people's housing, therefore, we will face a crisis in provision. The forthcoming Older People's Housing Strategy presents a good opportunity to address the future need for good quality housing with care for

older people, as will the review of the Supporting People programme. A vision of the 'lifelong home' should be developed to ensure that all new build is fit for purpose at all stages of people's lives. At every step, older people should be included in the planning and design of future housing if it is going to reflect their needs and aspirations.

The vast majority of older people express a wish to stay in their own home if possible rather than go into residential care. Sometimes this isn't possible, but the development of models such as extra care or very sheltered housing, could mean that people who would otherwise have no other option but to go into residential care are given more choice. There is not enough provision of high quality housing with care, however, and older people often find it difficult to access good advice and information about their housing options. The following case study supports this.

The daughter of Mrs M contacted Counsel and Care because her mother was in hospital and had been assessed as needing care in a care home. Both Mrs M and her daughter were quite distressed at the prospect of the move into a care home, preferring to keep Mrs M living on her own in her own home.

The move had become necessary because social services had decided that Mrs M's care needs were too high to be met by community care services. Due to her high level needs it was less expensive to place her in a care home than have round the clock services provided at home. Mrs M and her daughter were not able to afford to pay for the services themselves and so a move into a care home was presented as their only option.

Ensuring that older people are able to stay within the community is important to maintain their dignity and independence. The following could form part of increased support for developing housing options which enable older people to remain within their home or out of residential care as their care needs develop.

- Consideration should be given to developing a 'one-stop-shop' model for the provision of advice and support to older people for their housing and care needs.

- Extra support should also be considered for Home Improvement Agencies which provide much needed support for homeowners and private sector tenants who are older, disabled or on low incomes to repair, improve, maintain or adapt their homes.
- Removing means-testing for the Disabled Facilities Grant up to a limit of £1,000 as suggested in section 1 would also enable older people to remain within their home for longer.
- Similarly, recent demand for money for the Extra Care Housing Fund shows that there is a real need to fund more extra care schemes and thought should be given to increasing the fund in the future.<sup>82</sup>
- Regeneration and planning policies should recognise the needs of older people in local communities. An example of good practice is the Mayor of London's recent Older People's Strategy *Valuing Older People* which seeks to provide a future vision of older people as active, vital members of our communities.<sup>83</sup>

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<sup>82</sup> E-news from the Housing Learning & Improvement Network, Change Agent Team, October 2006

<sup>83</sup> *Valuing older people The Mayor of London's Older People Strategy*, September 2006

## Conclusion

Policy makers cannot escape the fact that any sustainable model of funding older people's care in the future will require extra resources. The question is how those extra resources should be allocated and what proportion of funding should be expected from individuals themselves. The current system is confusing and alienating for many older people who find the costs they have to bear unexpected and unjust. For a new system to command public respect there must be clarity about the need to share the costs of older people's care and the benefits older people can expect to receive in return. Older people with assets must be given support to use those assets in a way which will enhance their care options, but not decimate them entirely. In general older people must be given more choice with dedicated advice and information services to support their decisions.

Failure to map out a new vision for social care funding in the Spending Review 2007 will be a huge missed opportunity. The Wanless and Joseph Rowntree Foundation reports have provided some clear options for reform which provide a way forward for the Government. The CSR process could form the start of a crucial public debate about what a social care system in 10 years' time might look like. This paper argues that the following elements should be considered as part of that plan:

- Older people's entitlements to state support for care should be made explicit and be based on a comprehensive assessment of all care needs.
- Funding of older people's care should be fair and most importantly be seen to be fair giving the most support to those who cannot afford to pay for their care, but also not penalising those older people who have built up moderate assets.
- Continuing care criteria must ensure that older people with mental health needs such as dementia are treated with as much importance as those people with physical symptoms of ill health, and that all health

and social care staff are trained to be able to accurately assess who is eligible for the funding.

- Proposals for the Registered Nursing Care Contribution to be one payment per week, regardless of the level of nursing need, will undoubtedly simplify the current system of payment for nursing care in care homes. However, it must be ensured that the payment covers the actual costs of providing the nursing care, so that residents do not have to 'top up' this NHS contribution with their own funds.
- Local authorities should focus more investment on preventative services for older people on the basis of evidence about cost-benefits.
- The CSR should fund the Preventative Technology Grant beyond 2008 to ensure that local authorities comprehensively support telecare packages for older people.
- Removing means-testing for access to Disabled Facilities Grants for older people up to a maximum of £1,000 – thereby removing the potential for age discrimination.
- Local authorities should commission services for all older people and their carers within the community, not just those they support financially.
- Commissioning should be truly 'user-centred' and 'user-led' within a framework of national assessment of needs.
- Older people, their families and carers should have a right to access Independent care advisers within their local area to ensure they are given full information about their care and funding options to facilitate real choice and independence.
- Care vouchers should be introduced along similar lines to childcare vouchers to increase the amount of private money going towards care and to enable carers to balance their work and caring responsibilities.
- Carers' needs should be better recognised by ensuring that emergency care schemes and respite care are provided as a right rather than as an afterthought.
- A state supported equity release scheme should be piloted to enable those people who are not eligible for state support to better use their

assets to pay for care, and in particular to help them remain within their home for as long as possible.

- Once best practice has been gleaned from the Link Age Plus pilots, the idea of a Sure Start for Older People should be rolled out to every neighbourhood to act as a hub giving access to a wide range of services, particularly those which help with 'active ageing' and preventative care.

This is only the start of what could be an exciting opportunity to transform the social care landscape in the UK. As has become apparent in the debate leading up to the Government's announcements on pensions, leading the public in a discussion about the options for reform is the only way to generate a consensus about the way forward. Such an approach will be vitally important in mapping out the future of older people's care. There is a strong political imperative too. Older people and their families and carers will not remain content with the status quo, presenting politicians with a stark choice of facing up to the challenge or facing rejection at the polls. Seizing the opportunity of the Comprehensive Spending Review will send a signal that the Government is serious about developing a social care settlement which is fit for the future.

## About Counsel and Care

Counsel and Care is a national charity getting the best care and support for older people, their families and carers. We work with older people and their carers to ensure they are aware of and receive their rights and entitlements, and promote choice and control in later life. We operate an advice service which deals with 25,000 enquiries per year, through telephone calls, emails, letters and our website. The frequency of contact we have with older people and the issues raised through this service are used to inform our campaigning and lobbying work.

The advice service is an expanding part of the organisation as ever-increasing numbers of people are in need of advice and guidance about issues affecting older people, particularly on care and support. Enquiries are answered in detail and are followed up with a tailored letter which emphasises the options available in each case, and which provides a resource which people can revisit for future guidance. We publish a full range of factsheets covering community care issues in England, Wales and Scotland.

More information about this report can be obtained by contacting Elizabeth McLennan at [elizabeth.mclennan@counselandcare.org.uk](mailto:elizabeth.mclennan@counselandcare.org.uk) or 020 7241 8523.

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