Long-term care : future provision and funding : third report. Vol. I, Report, together with the proceedings of the Committee / Health Committee.

HOUSE OF COMMONS SESSION 1995–96

HEALTH COMMITTEE

Third Report

LONG-TERM CARE: FUTURE PROVISION AND FUNDING

Volume I

Report, together with the
Proceedings of the Committee

Ordered by The House of Commons *to be printed*
25 July 1996
pursuant to Standing Order No. 119

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The Health Committee is appointed under Standing Order No. 130 to examine the expenditure, administration and policy of the Department of Health and associated public bodies.

The Committee consists of 11 Members. It has a quorum of three. Unless the House otherwise orders, all members nominated to the Committee continue to be members of it for the remainder of the Parliament.

The Committee has power:

(a) to send for persons, papers and records, to sit notwithstanding any adjournment of the House, to adjourn from place to place, and to report from time to time;

(b) to appoint specialist advisers either to supply information which is not readily available or to elucidate matters of complexity within the Committee's order of reference;

(c) to communicate to any other committee appointed under the same Standing Order (or to the Committee of Public Accounts and to the Deregulation Committee) its evidence and any other documents relating to matters of common interest;

(d) to meet concurrently with any other such committee for the purposes of deliberating, taking evidence, or considering draft reports.

The membership of the Committee since its nomination on 13 July 1992 has been as follows:

Mrs Marion Roe was elected Chairman on 15 July 1992

Mr John Austin-Walker *(added 12.12.94)*
Mr Michael Bates *(added 6.12.93 and discharged 27.6.94)*
Mr Hugh Bayley *(added 26.10.92)*
Mr Roland Boyes *(discharged 26.10.92)*
Mr James Clappison *(discharged 24.1.94)*
Mr David Congdon
Mr Iain Duncan Smith *(added 24.1.94 and discharged 10.7.95)*
Mr Jonathan Evans *(added 27.6.94 and discharged 28.11.94)*
Mr David Hinchliffe *(discharged 26.10.92)*
Tessa Jowell *(added 26.10.92 and discharged 12.12.94)*
Mr Robert Key *(added 28.11.94 and discharged 1.5.95)*
Mrs Jacqui Lait *(discharged 6.12.93)*
Alice Mahon
Lady Olga Maitland *(added 10.6.96)*
Mr John Marshall *(added 10.7.95)*
Sir Roger Sims
Rev Martin Smyth
Mr Richard Spring *(added 1.5.95 and discharged 10.6.96)*
Mr Michael Trend *(discharged 5.7.93)*
Mr John Whittingdale *(added 5.7.93)*
Audrey Wise

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THIRD REPORT

THE FUTURE FUNDING AND PROVISION OF LONG-TERM CARE

The Health Committee has agreed to the following Report:

I — INTRODUCTION

1. In November 1995 we reported the results of the first part of our inquiry into long-term care. This considered the implications of guidance published by the Department of Health (DoH) in February 1995 to health authorities, local authorities and other interested parties clarifying NHS responsibilities for meeting continuing health care needs.[1] In our report we stated that the second phase of our inquiry would consider some of the wider issues relating to long-term care, and in particular the implications of the projected growth in the numbers of elderly people and in the costs of their care. In Section IV of that report we set out the four issues we proposed to explore:—

- what models of care exist for long-term care services?
- who should manage long-term care?
- what are the cost implications of long-term care, given the projected demographic trends?
- what are the potential options for paying for long-term care?[2]

2. During the second phase of our inquiry we have taken oral evidence from witnesses representing Anchor Housing, the Association of British Insurers (ABI), the Association of County Councils (ACC), the Association of Directors of Social Services (ADSS), the Association of Metropolitan Authorities (AMA), Age Concern England, the Age Concern Institute of Gerontology at King's College London, the British Geriatrics Society (BGS), Help the Aged, the Institute and Faculty of Actuaries, the National Association of Health Authorities and Trusts (NAHAT), the National Association of Pension Funds (NAPF), PPP Lifetime Care plc, the Prudential Assurance Company Ltd and the Royal College of Nursing (RCN). We also took evidence from the following individuals: Professor J Grimley Evans, Mr William Laing and Professor Brian Livesley. Our final witness was the then Parliamentary Under-Secretary of State for Health, Mr John Bowis MP, accompanied by DoH officials. During the course of the inquiry we visited Germany, Japan and Singapore, three countries where, as in the UK, a combination of demographic and medical developments has called into question the future affordability of welfare and health programmes. We also visited Northern Ireland, to inspect the Intensive Homecare Scheme operated by South and East Belfast Health and Social Services Trust.

3. The Committee also received 134 memoranda from 105 individuals and organisations, including patient and carer organisations, representatives of the health and social services sectors, the independent healthcare sector and the financial services sector.

4. We would particularly like to express our thanks to our specialist advisers: Mr Peter Gatenby, Appointed Actuary, PPP Lifetime Care plc, Dr Peter Horrocks, formerly Manager, Community/Priority Services, Yorkshire Regional Health Authority, and Professor Gerald Wistow, Professor of Health and Social Care at the Nuffield Institute for Health, University of Leeds.

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[1] First Report from the Health Committee, Session 1995-96, *Long-Term Care: NHS Responsibilities for Meeting Continuing Health Care Needs*, HC 19-I.

[2] HC 19-I, paras 96-106.

5. As was the case during the first phase of our inquiry, much of the evidence we received focused on long-term care services for elderly people. Our report again reflects this emphasis. We do, however, recognise that many long-term care services are provided for client groups other than elderly people, and our conclusions and recommendations should be read in that light.

6. Our report is structured as follows. Section II describes how the current system for providing and financing long-term care operates, and highlights a number of consequences of that system. Section III discusses the changing demographic and social context within which public policy decisions relating to long-term care must be taken. In Section IV we provide a brief overview of recent projections of the future cost of long-term care. In Section V we present a set of key principles which should underpin any future changes to the system of providing and funding long-term care. Section VI discusses the different funding options that were proposed by our witnesses, and analyses the advantages and disadvantages of each option for society as a whole and for different groups within society. Finally, in Section VII we set out our recommendations for the further action that is required.

7. The large number of memoranda we received and the many recent publications discussing the issue of long-term care highlight the high degree of public interest in this subject. Much of the interest has focused on two particular issues, namely whether the current system of paying for long-term care is equitable, and whether demographic and other social trends are such that we as a country face a crisis in affording long-term care over the decades to come.

8. Since we began our inquiry the Government has announced changes to some of the regulations governing payment for long-term care. In his Budget Statement on 28 November 1995, the Chancellor of the Exchequer announced increases in the thresholds used in the means-test which determines whether individuals are required to make a contribution towards the cost of their social care.[3] He also announced that the Government would consult on proposals to encourage people to make provision for long-term care through insurance, and on changes to occupational pension schemes to allow people to take a variable pension (which could provide a larger pension in later years in exchange for a smaller pension earlier on). A consultation paper entitled *A new partnership for care in old age* was published on 7 May 1996, with responses requested by 14 June.[4] We comment on the Government's proposals in Section VI of this report.

9. Our conclusions and recommendations are set out at the end of each section of the report, and are summarised on pages lxi to lxix. We think it worth drawing attention to one of these conclusions, a very significant one, at the outset. **There has been considerable media and public speculation about the 'crisis' the country supposedly faces in paying for long-term care in the future. We believe that much of this speculation has been founded on unsound evidence, or indeed been downright alarmist, and that the problems the country faces in relation to paying for long-term care, although real, are more manageable than many recent commentators have suggested.** We set out our reasons for drawing this conclusion in Sections III and IV below.

II — OBSERVATIONS ON THE CURRENT SYSTEM

Background

10. In paragraph 10 of our earlier report we set out the DoH's stated objectives for community care, as summarised in the white paper *Caring for People*, issued in November 1989. These objectives, which remain in force, are:—

> "● to enable people to live as normal a life as possible in their own homes or in a homely environment in the local community;

[3] *Official Report*, 28 November 1995, cc1067-68.

[4] Cm 3242, May 1996.

- to provide the right amount of care and support to help people achieve maximum possible independence and, by acquiring basic living skills, help them to achieve their full potential; and

- to give people a greater individual say in how they live their lives and the services they need to help them do so."[5]

11. There is a wide range of long-term care services available to people with personal, social or health care needs. Most social care is provided on an informal basis by family, friends and neighbours. Figures from the 1990 General Household Survey suggest that there were some 6.8 million carers in Great Britain. Of these, some 1.5 million people undertake informal caring for more than 20 hours per week, half of these for more than 50 hours.[6] Formal long-term care for elderly people is provided in a range of settings and with varying degrees of intensity. Some people receive services in their own homes: either arranged (but not necessarily provided) by statutory agencies, mainly health, social services and housing; or arranged privately. Others require full-time residential or nursing home care or long-term care in hospital.[7]

12. The NHS and Community Care Act 1990 gave local authority social services departments the lead role in planning community care services for the overall needs of their population, as well as responsibility for purchasing suitable packages of care for individuals. Such packages of care should, wherever possible, include domiciliary services designed to enable people to live as independently as possible in the community, as well as provision of residential and nursing home places. District Health Authorities (DHAs) are responsible for ensuring that the health needs of their resident populations are met.[8] A significant recent development has been the requirement for health authorities to develop local policies and eligibility criteria for entitlement to NHS-funded continuing health care in consultation with local authorities and other agencies. This came into effect in April 1996.[9] We commented in detail on this development in our earlier report.[10]

13. Housing authorities are expected to co-operate with social services departments and health authorities in implementing community care. They are responsible for assessing individuals' needs for mainstream or special needs housing and for providing grants for home repairs and adaptions.[11]

14. NHS care, both in the hospital and the community, is funded from general taxation, with some payments from individuals for items such as prescriptions, optical and dental treatment. Social care services arranged by local authorities are largely funded from public expenditure, but with some payments from individuals towards the costs of all adult residential care, and most non-residential services. However, these payments are means-tested, with around 75% of total local authority spending on residential care, and over 90% of their spending on day and domiciliary services, being met from authorities' own resources rather than from charges to individuals.[12] Since 1948 the law has obliged all local authorities to charge for the residential services they arrange, with little leeway in how they calculate any contributions due from individuals.[13] Local authorities also have, and most now use, discretionary powers to decide whether — and how much — to charge users for day and domiciliary services.[14] Those who make private arrangements for their own social care

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[5] Cm 849, November 1989, p4.

[6] *General Household Survey: Carers in 1990*, OPCS Monitor SS92/2, November 1992.

[7] Ev. pp257-8.

[8] Ev. p259.

[9] DoH Circular HSG(95)8, *NHS Responsibilities for Meeting Continuing Health Care Needs*.

[10] HC 19-I, paras 47-62.

[11] Ev. p259.

[12] *A new partnership for care in old age*, Cm 3242, May 1996, paragraph A.18.

[13] *Charging consumers for social services: local authority policy and practice*, National Consumer Council, September 1995.

[14] Ev. p392.

services (either residential or non-residential) meet the costs charged by the providers.[15] The DoH estimate that around 25% of people in residential care meet their own costs in full.[16]

15. There is currently much controversy as to the operation of the means test for residential and nursing home care. We think that it would be useful briefly to set out how it works.

16. The care provided in a residential or nursing home is intended to meet almost all of an individual's needs. Because of this, the basic principle of the means test applied by local authorities is that most of a resident's resources should be available to contribute towards the cost of care.[17] Almost all forms of income are taken into account in the assessment of how much an individual can contribute, but individuals are allowed to retain part of their income as a personal expense allowance (currently £13.75 per week).

17. The assessment also takes account of an individual's capital, such as savings, investments and property. From April 1996 no account has been taken of capital up to £10,000. For capital between £10,000 and £16,000, an income of £1 per week is assumed for each £250 held. This assumption might be criticised on the grounds that at current levels of interest rates no such income (which would require annual interest of the order of 20%) is likely to be realised. However, one also has to take into account the returns that can be available on the first £10,000 of assets.[18] The Government has argued, since the introduction of the assumed income calculation of £1 for every £250 of capital in 1988, that "the formula... is not linked to, nor is it meant to imply, any particular rate of return that could be secured from investments"[19] and that the arrangements "gradually reduce the amount of benefit ... to those with higher amounts of capital".[20] Capital over £16,000 is assumed to be wholly available to pay for residential care.[21] Prior to April 1996 these capital thresholds were £3,000 and £8,000 respectively. Around three-quarters of the 369,000 people in residential care had assets below the earlier £8,000 threshold; the former Parliamentary Under-Secretary, Mr Bowis, told us that the April 1996 changes would benefit a further 50,000 people.[22]

18. The value of a resident's home is generally taken into account in an authority's calculation of available capital. A local authority must ignore the value of a property where the resident's partner, or a dependant, continues to live there; and the authority has the discretion to ignore the value of property in other circumstances where someone (for example, an adult son or daughter who was the former carer) lives there.[23] If the value of property is sufficient to be taken into account in the financial assessment and the resident is not willing or able to sell the property, local authorities have the power, under sections 22-24 of the Health and Social Services and Social Security Adjudications Act 1983, as amended by the NHS and Community Care Act 1990, to place a charge on that property, thereby enabling the authority to recover the debt when the property is sold. The DoH told us that one of the reasons for giving local authorities this power was to reduce any need for them to enforce the sale of property. A local authority cannot enforce the sale of a property without first obtaining a court order.[24] The court will consider what would be fair in the individual

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[15] Ev. p261.

[16] *Official Report*, 11 June 1996, c112w.

[17] *A new partnership for care in old age*, Cm 3242, May 1996, paragraphs B2-3.

[18] For someone with £11,000 of assets, the amount of deemed income would be £208 (£4 per week for 52 weeks); this equates to a return of 1.9 per cent a year.

[19] *Official Report*, 19 November 1992, c361w.

[20] *Official Report*, 6 November 1991, c149w.

[21] *A new partnership for care in old age*, Cm 3242, May 1996, paragraph B5.

[22] Q745.

[23] *A new partnership for care in old age*, Cm 3242, May 1996, paragraph B6.

[24] Ev. p399.

circumstances of each case, and can take into consideration the presence of someone in the home, the size of the outstanding debt compared to the value of the asset, and the effect on other creditors.[25]

19. At 31 March 1995 there were 107,000 local authority supported residents in residential care placements for elderly people and people with physical and/or sensory disability. In addition local authorities supported 40,000 residents in nursing homes.[26] In May 1995 the Department of Social Security (DSS) were also supporting 67,000 people in residential homes for elderly and physically handicapped people, and 67,000 in nursing homes.[27] These DSS-supported people entered residential care before 1 April 1993 with the help of special higher levels of Income Support which, prior to this date, was available to those who could not meet the full fees themselves. Since April 1993 local authorities have become the only source of state funding for those entering residential care. People who entered residential care before April 1993 with the help of Income Support, or who were self-funding their care at that date, retain 'preserved rights' to these levels of Income Support.[28]

20. In our earlier report we drew attention to the difficulties which have arisen when home charges exceed the preserved rights figure. We recommended that "the DoH seek evidence from all local authorities as to the current scale of the problem... and in consort with the DSS, conduct a review of the existing arrangements... with the aim of ensuring that no elderly residents should face eviction in the future."[29] In response, the DoH stated that "local authorities and the DoH are not in direct contact with the majority who have preserved rights... as they remain the responsibility of the DSS."[30] We are very disappointed with the Government's response, which attempts to shuffle off responsibility and does nothing to meet the needs of some of the most vulnerable members of society. We repeat our recommendation that the DoH, in conjunction with the DSS, should review the situation.

21. In 1994, the NHS provided 37,500 beds specifically designated as being for elderly people, although in our earlier report we noted that the DoH did not collect information on the numbers of NHS long-stay places for elderly people.[31] From April 1996 the DoH propose collecting information on the number of people (and occupied bed-days) meeting eligibility criteria for receiving NHS-funded continuing inpatient care.[32]

22. In our earlier report we highlighted the changes that have occurred in the relative provision of long-term care places by the private and public sectors. Table 1 shows that in 1983, of the 280,000 long-term care places available, the NHS provided 20%; the private/voluntary nursing home sector 6.5%; local authorities 41.5%; the voluntary residential home sector 13%; and private residential home sector 19%. By 1994, of the 465,000 places available, the NHS provided 8%; the private/voluntary nursing home sector 32%; local authorities 15%; the voluntary residential home sector 10%; and the private residential home sector 35%.[33]

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[25] *Charging consumers for social services: local authority policy and practice*, Appendix E, National Consumer Council, September 1995.

[26] Ev. pp393,395.

[27] Laing & Buisson, *Care of Elderly People Market Survey 1996 — Ninth Edition*, p106.

[28] *A new partnership for care in old age*, Cm 2342, May 1996, paragraph B12.

[29] HC 19-I, para 95.

[30] Government response to the First Report of the Health Committee of Session 1995-96, Cm 3146.

[31] HC 19-I, para 13.

[32] DoH Executive Letter EL(95)88, *NHS Responsibilities for meeting continuing health care needs — NHS Executive/SSI monitoring*, August 1995.

[33] HC 19-I, Table 1. These percentages exclude NHS places for elderly people with mental health problems, data on which was not available in 1983.

Table 1: Distribution of long-term care places for elderly people by sector: 1983 and 1994

	1983	1994
Total number of long-term care places	280,000	465,000
NHS places (% of total)	55,600 (20)	37,500 (8)
Private/voluntary nursing home sector (% of total)	18,200 (6.5)	148,500 (32)
Local authority Part III residential home sector (% of total)	115,900 (41.5)	68,900 (15)
Voluntary residential home sector (% of total)	37,600 (13)	45,500 (10)
Private residential home sector (% of total)	51,800 (19)	164,200 (35)

Source: HC 19-I, Table 1. These percentages exclude NHS places for elderly people with mental health problems, data on which was not available in 1983.

23. Over 512,000 households were receiving domiciliary care services funded by local authorities in September 1995, with over 2.4 million contact hours provided. The comparable figures for September 1992 were 528,000 households receiving 1.7 million contact hours.[34] These statistics show that the intensity of home help/care services has steadily increased, as anticipated, since the introduction of the community care reforms, with the average number of contact hours rising from 3.0 per household in 1992 to 4.7 in 1995. In 1992, 58,000 households (11% of all households) received more than five contact hours, and six or more visits a week; by 1995 the number had increased to 108,000 households (21%).[35] The DoH does not have comparable information on the intensity of district nursing services provided by the NHS, although they told us that they had begun to collect such information from April 1995.[36] The number of face-to-face contacts undertaken by the district nursing service fell from 39,225 in 1988-89 (when data was first collected in this format) to 37,422 in 1991-92, a fall of 5%, but rose again by nearly 2% in the period to 1994-95 to 38,036.[37] The number of district nurses fell from 9,390 in September 1988 to 8,680 at September 1994. The DoH told us that some basic workload previously undertaken by district nurses and health visitors was now undertaken by nurses employed in primary care and in general practice settings. Practice nurse numbers increased over the same period from 3,480 to 9,099.[38]

24. The DoH has estimated that the average length of stay in a residential home is three years, and in a nursing home one and a half years. These average lengths of stay conceal considerable variations between individuals: for example, nearly 25% of those in residential homes, and about 10% of those in nursing homes, are estimated to stay for more than four years.[39]

25. There are no nationally collected statistics about the characteristics of people in institutional care, such as dependency levels and sources of admission. A local study of dependency levels of residents in different types of long-term care establishments (NHS, local authority residential home, private residential home and private nursing home) in York found that there was a considerable degree of overlap between the types of clientele being cared for.

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[34] *Community Care statistics 1995*, DoH Statistical Bulletin 1996/5. These statistics are based on information provided by local authorities in a sample week in September 1995.

[35] Ibid.

[36] Ev. pp271-2.

[37] Ibid.

[38] Ibid.

[39] Cm 3242, para A14.

In this sample 50% of private nursing homes residents were evaluated as being in the maximum dependency category as compared with 19% of those in residential homes and 82% of NHS geriatric patients.[40] A survey of residential and nursing homes in 17 local authority areas by the Personal Social Services Research Unit and the Centre for Health Economics in 1986-1987 found similar overlaps in dependency levels for individuals in residential and nursing homes. The results also suggested that alternative forms of provision might have been suitable for a proportion of residents in residential care and for a smaller proportion of nursing home patients.[41]

26. Obtaining accurate information on how much the nation as a whole spends on long-term care services is rendered more difficult by the fact that services are purchased privately by individuals, in addition to those funded by the State.

27. Estimates from the consultants Laing & Buisson indicate that the total market value of residential care provided by the private, voluntary and state sectors for elderly, chronically ill and physically disabled people was just over £8 billion as at April 1995. A further £3.7 billion was estimated as being spent on non-residential care, that is NHS, social services and privately organised domiciliary care. All these figures should be treated with caution, being based on extrapolations from other available data. For example, estimates for privately purchased domiciliary services are based on extrapolation of data from the 1985 OPCS survey of the extent of disability.[42]

28. The DoH provided us with an estimate of publicly funded long-term care costs in 1995-96 which indicated that social services expenditure on long-term care was £6 billion and NHS expenditure £8 billion.[43] These figures relate to a wide range of health and social services for people with continuing care needs. The social care figure includes all social services provided for adults, valued at net costs (after taking account of user charges). The NHS figure includes all community health services for adults, as well as inpatient, outpatient and day care for adults in the geriatric, mental illness and learning disabilities specialties. The DoH estimates therefore encompass a much wider range of services than the Laing & Buisson estimates we quoted in the previous paragraph.

29. At the national level it is clear that the total costs of providing long-term care are high. For the individual also, long-term care costs can be a significant expense, particularly if residential or nursing care is being purchased. Laing & Buisson report that the average cost per week for a single place in a nursing home is £347 (£18,000 annually) in England, varying from £314 (£15,000 annually) to £469 (£24,400 annually) across the country. Residential care can cost about £244 per week (£12,700 annually) in England, (varying from £225 per week (£11,700 annually) to £322 (£16,700 annually) across the country.[44]

30. Estimates of residential and nursing home fee inflation by Laing & Buisson, based on an annual survey of residential and nursing homes, indicate that local authorities have had some success in constraining fee inflation. In the last two years this has been around 1% to 3%, compared to increases of around 10% in the 1980s.[45] Recently published research undertaken for the Local Government Management Board, ADSS, ACC, AMA and NAHAT supports this conclusion. Based on a survey of local authorities, the research concluded that "authorities appear to have been successful in limiting fee increases for elderly people, especially in residential homes".[46]

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[40] Laing & Buisson, *Care of Elderly People Market Survey 1996 — Ninth Edition*, page 81.

[41] *Residential and Nursing Home Care for Elderly People: Results of Recent PSSRU Research*, R.A Darton, PSSRU, July 1994.

[42] Laing & Buisson, *Care of Elderly People Market Survey 1996 - Ninth Edition*.

[43] Ev. pp264-266, 268.

[44] *Care of Elderly People Market Survey 1996 - Ninth Edition*, Section 5.

[45] Ibid, Section 8.

[46] *Community Care Trends: The Impact of Fundin[illegible] Authorities*, London Research Centre, April 1996.

31. Representatives from the independent residential and nursing-home sectors claimed in evidence to us that local authorities should be making more use of the independent sector due to its superior cost-effectiveness, compared to local authority Part III residential homes.[47] When this argument was put to Councillor Jack Bury of the ACC, he disputed its validity, arguing that in making comparisons one had to look at the level of services that were provided in each sector, and that there was evidence that many residents wish to remain in local authority homes.[48] The Audit Commission have reported that the costs of local authority residential homes fall mostly in-between the costs of independent residential and nursing homes. It pointed out that these cost differences could reflect the relative dependency of individuals, the quality of care, or the costs of providing extra care; but that they may also be the result of inefficient services.[49] With the limited evidence that we received we are unable to draw any firm conclusions on this issue, but we welcome the announcement by the Government that social services departments are to face tougher scrutiny through joint reviews by the Social Services Inspectorate and the Audit Commission, in which the cost-effectiveness and quality of services will be closely examined in 20 authorities each year.[50] It is, however, important that sufficient regard should be paid to the wishes of residents.

32. A significant minority of people are likely, at some stage in their life, to need long-term care services. What people are not able to predict is how severe their needs are likely to be, or for how long they are likely to need care. During the course of the inquiry a number of claims were put forward as to the statistical chances of an individual needing long-term care. The former Parliamentary Under-Secretary, Mr Bowis, claimed that the risk that a 40-year old person would need long-term care at some stage in the future was one in six.[51] The DoH later told us that they themselves had not calculated the likelihood of an individual needing long-term care but that they were aware of estimates made by insurance interests, in particular those set out below:—

- Munich Re estimate that at the age of 40, the lifetime risk of needing residential care is 18% for a man and 33% for a woman.

- Swiss Re estimate that on reaching retirement age the likelihood of needing "full-time long-term care" is one in six for a man, and one in four for a woman. Swiss Re told us that these estimates were calculated using unpublished data from the 1985 OPCS Survey on Disabled Lives and their own estimates of mortality rates for the non-disabled population.[52]

- Hambro Assured Life estimate that at the age of 65 the likelihood of needing some form of care (not necessarily residential) is one in four, and at the age of 80 seven in ten.[53] Hambro subsequently told us that their estimate was taken from the 1985 OPCS Survey. It thus reflects the proportion of the population aged 60-69, and 80 and over, who were disabled at the time of that survey in 1985.[54]

Mr Brian Wood of PPP Lifetime plc talked about "one in four people maybe requiring continuing care".[55] Other witnesses cited similar figures which appear to derive from one or other of the sources cited by the DoH.[56]

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[47] Ev. pp303,316.

[48] Q701-02.

[49] *Balancing the Care Equation: Progress with Community Care*, Audit Commission Community Care Bulletin Number 3, March 1996.

[50] DoH Press Release 96\137, 24 April 1996.

[51] Q744.

[52] Ev. p399.

[53] Ev. p392.

[54] Ev. p399; *OPCS Disability Survey, Report 1: The prevalence of disability among adults*, OPCS, September 1988.

[55] Q77.

[56] Ev. pp40,378.

33. These estimates of future risk are unavoidably speculative. The proportion of people *currently* receiving institutional care in each age group is easier to ascertain. According to statistics from the consultants Laing & Buisson, the proportion is as follows: under the age of 65, 0.05%; aged 65-74, 1%; aged 75-84, 5.5%; and over the age of 85, 25.2%.[57]

Table 2: Proportion of the population currently receiving institutional care

Age	Proportion of people currently receiving institutional care (percentage)	Proportion of people currently receiving institutional care (one in x)
Under 65	0.05	1 in 2000
65 to 74	1	1 in 100
75 to 84	5.5	1 in 20
Over 85	25.2	1 in 4

Source: Laing & Buisson, *Care of Elderly People Market Survey 1996 — Ninth Edition*, Table 1.2.

Models of Care

Domiciliary care services

34. The underlying policy objective of the Community Care reforms has been to improve domiciliary care services so as to enable more people to be cared for at home, if that is their wish. In our earlier report we urged the DoH and local authorities to ensure that preventative services remained a core responsibility of both health authorities and social services departments.[58] In response the Government said that it

> "expects health and local authorities to keep in view the role of preventative services in minimising the needs of their populations for long-term care. There may be a variety of ways to provide the kind of preventative services envisaged by the Committee; health and local authorities should, for example, take account of the supervisory role of wardens in sheltered housing, or voluntary organisations which are in touch with individuals on a less formal basis. General Practitioners are required under the terms of their contract to offer an annual health check for every individual aged 75 or more, in order to identify and deal promptly with any emerging health problems."[59]

35. Giving evidence in the second phase of our inquiry, Mr Mervyn Kohler of Help the Aged expressed concern that domiciliary care services had not expanded adequately to provide what he described as "basic housekeeping support".[60] Anchor Housing echoed these concerns, telling us that there "is evidence of tightening eligibility criteria for community care services and a reduction in preventative services, such as practical support in the home."[61] Mrs Evelyn McEwen of Age Concern told us that one of the things that elderly people have complained about most under the new system was that the preventative aspects of domiciliary care services appeared to have fallen by the wayside.[62] Professor Anthea Tinker told us of research conducted by Age Concern London which indicated that basic cleaning services were

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[57] Laing & Buisson, *Care of Elderly People Market Survey 1996 - Ninth Edition*, Table 1.2.

[58] HC 19-I, para 29.

[59] Cm 3146, para 4.

[60] Q287.

[61] Ev. pp196-7.

[62] Q289.

now often not available; she considered that this was a worrying fact particularly in the light of the fact that many older people "do not like seeing their houses dirty and may be tempted to take risks which may lead to falls".[63]

36. The latest published statistics relating to home help/home care services show a move towards a more intensive service. In 1992, 290,000 households (55% of households with local authority arranged domiciliary care services) received up to 2 hours' care a week, but by 1995 this figure had dropped to 280,000 (45% of households).[64] This is a cause of some concern, because it suggests that local authorities are not making the most effective use of preventative services. When asked to comment on the priority given to low intensity home care/help services, the former Parliamentary Under-Secretary, Mr Bowis, argued that there was "clear evidence that low intensity services were being provided" and he pointed out that, in 1994, more households were receiving low intensity services than high intensity services.[65]

37. While Mr Bowis' statement is factually correct, there is a clear trend towards the provision of high-intensity services, both in terms of the numbers of contact hours provided and in the numbers of visits made. While we welcome the development of packages of care which allow more people with high levels of dependency to be cared for in their own home, if they so wish, we would not expect local authorities, health authorities and housing agencies to lose sight of the fact that preventative services can play an important role in delaying, or reducing, the demand for long-term care in some cases. It is potentially counterproductive for authorities not to invest in preventative services, as this may only lead to the earlier onset of the demand for long-term care, often at a 'crisis point' in the life of an individual needing care.

38. It is particularly important that the full value of a properly arranged home-help service is understood. There are merits in such a service whether or not it serves to delay the need for institutional long-term care. There are many people who may benefit, in terms of continuing to live independently in their own home, from relatively low levels of domiciliary services, such as cleaning and other basic housekeeping services. We are concerned by Professor Tinker's evidence suggesting that basic cleaning services are often now unavailable. For an old or disabled person, help in cleaning the house is often at least as important as help with shopping, both because it assuages the mental anxiety and loss of self-esteem that may follow from inability to keep a house clean, and because it is easier to ask neighbours or relatives to go on shopping errands than it is to ask them to undertake basic cleaning tasks. We believe that local authorities should ensure that they take account of the wishes of service users as to the type of services that are arranged on their behalf.

39. One consequence of the move towards more intensive home care services is that there is now a debate about the extent to which local authorities are justified, on cost grounds, in providing these very intensive care packages. They can involve the provision of very high levels of service, and sometimes cost more than a residential home place or even a nursing home place. As the ACC commented "inevitably there will come a time when the cost of keeping someone at home, because of the complexity and volume of services being arranged, has to be weighed against alternatives because of the pressure on resources".[66]

40. The ACC also told us that residential or nursing home accommodation was a more economic way of delivering long-term care to people at risk because of economies of scale and mandatory charging and financial assessment rules.[67] Councillor Jack Bury of the ACC told us that it was now a widespread practice for local authorities to limit the cost of

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[63] Q352.

[64] *Community Care statistics 1995*, Table A1.3, DoH Statistical Bulletin 1996/5. These statistics are based on information provided by local authorities in a sample week in September 1995.

[65] Q808.

[66] Ev. p225.

[67] Ibid.

domiciliary care packages to the cost of a place in a residential care home.[68] Ms Denise Platt of the Association of Metropolitan Authorities (AMA) said that she understood, on the basis of a letter from an official at the DoH to a member authority of AMA, that it was the DoH's "expectation" that local authorities should accept such a cost limitation.[69] The former Parliamentary Under-Secretary, Mr Bowis, however, told us that there are no "national requirements on what the absolute maximum cost [of a domiciliary care package] should be" and that what is a reasonable cost would depend on the "subjective judgement of the elected members who are responsible for the management of care in that area".[70] Authorities had to balance the interests of the individual being assessed against the wider needs of the community, taking into account local guidance. This meant that there might be some cases "on which the authority will decide it is reasonable to spend more than would be spent in residential care in order to enable somebody to have that independence of staying at home, maybe a young disabled person for example".[71]

41. During the course of our inquiry we visited Belfast and learnt at first hand about a very impressive domiciliary scheme, the Intensive Homecare service provided by South and East Belfast Health and Social Services Trust. This offers frail, functionally dependent people an alternative to nursing home or NHS long-stay care by providing a 24-hour service in their own home. (The Trust also purchases, on a means-tested basis, residential and nursing home care packages for those assessed as needing such care.)[72] Under the Intensive Homecare Scheme each client has a Primary Worker, who will visit him or her up to five times each day and will carry out a range of personal, domestic and social care tasks. All care workers receive an extensive and on-going training programme covering all aspects of the care they provide. The service is targeted at clients whose needs can no longer be met by traditional services and who would otherwise require nursing home or long-term geriatric hospital care. Functional dependency levels are used to provide a basis for eligibility criteria. The two levels currently adopted are known as Level 2 (client immobile, bed or chair bound, incontinent, unable to assist with any aspect of personal care) and Level 3 (client bed bound, doubly incontinent, also unable to assist with any aspect of personal care). The Trust acknowledges that Level 3 clients are extremely dependent, but claims that "within Intensive Homecare we have shown that we can provide for any level of dependency as long as the client is medically stable". As at March 1995, Level 3 clients comprised 40% of the total number. The Trust told us that an independent evaluation of the service by the University of Ulster had found that 85% of clients rated it as "excellent" and 15% as "very good".[73]

42. We were informed that the average cost per week of providing care for Level 2 clients is £278, and for Level 3 clients £404. The Trust claims that "in terms of gross cost, Intensive Homecare is comparable with nursing home cost". (Laing & Buisson give £347 as the average cost for nursing home care in England, ranging from £314 to £469 across the country.)[74] Clients in Belfast are not currently required to contribute towards the costs of providing their care. This contrasts with the situation in England, where clients of such a personal care service would be expected to contribute towards its cost, subject to a means test. However, the South and East Belfast Health and Social Services Trust is now unhappy with the policy of not charging, claiming that, in their belief, many clients are willing to pay for the service (although we did not receive any direct evidence from clients to support this view). They also claimed that the present arrangement creates a perverse incentive,

> "particularly for home owners whose home in many instances is considered as part of the financial calculations when they are admitted to nursing home care ... we have again an 'uneven playing field' where institutional care has a charge and homecare is free".[75]

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[68] Q680.

[69] Q681.

[70] Q784.

[71] Ibid.

[72] *Who Cares? 1994-95 Annual Report and Accounts*, South & East Belfast Health and Social Services Trust.

[73] Ev. pp385-392.

[74] See para 29 above.

[75] Ev. p386.

43. A factor which undoubtedly contributes to the success of the Intensive Homecare Scheme is the fact that in Northern Ireland, unlike in England, health and personal social services are managed by an integrated health and social services authority. There are, of course, other factors involved also. In particular, we were struck during our visit by the obvious commitment of managers and staff to providing a high-quality service. We believe that the fact that in England separate organisations are responsible for purchasing and organising different aspects of health and social care ought not to preclude the effective organisation of services similar to that offered in Belfast. Indeed, we are aware of a number of examples of good practice in England, including schemes operating in Kent, Gateshead and Darlington which seek to target individual cases where there is potential for substituting home-based for institutional care.[76] Clearly, the absence of integrated authorities on the Ulster model acts as a disincentive to the setting up of such schemes, by creating difficult questions over who provides funding, what charging arrangements should apply, which authority should manage and train the staff, and so on; and we comment on the relationship between health, local and housing authorities later in this section of our report. Nonetheless, **we are convinced that care services such as those available through the Belfast Intensive Homecare Scheme could be successfully provided on a wide scale in England.**

Domiciliary Care: Conclusions

44. **We endorse the objectives of the Community Care reforms, those of promoting personal choice wherever possible and enabling people to live independently in the community. We have noted above the great value to many elderly and disabled people, both in preventative and other terms, of relatively low-intensity domiciliary services, such as cleaning. We also welcome the extension of opportunity for people with higher levels of dependency to be looked after in their own homes, if this is their wish. There will, of course, always have to be a judgement made as to what is the level of cost above which domiciliary care packages cease to be realistically affordable, bearing in mind the equally valid needs of other people in the wider community. The question of where to locate this cut-off point is a difficult one, and we can understand why the Government has decided that it is a matter best left to local discretion. Our own view is that a cut-off point at about the cost of a nursing-care place is not unreasonable, if treated as a guideline; and we note the success of the Belfast Intensive Homecare Scheme in providing a high level of service within this cost constraint. We do, however, believe that there should be local discretion to exceed this limit in circumstances deemed to be exceptional. The wishes of service users should be taken fully into account in any decisions over the level of domiciliary care to be provided: for instance, some people may *prefer* to receive care in a communal setting due to the greater opportunities for social interaction that such a setting can provide.**

45. The Audit Commission have commented recently that the financial incentive to use residential care remains strong. They did so on the basis of their research which showed that in nearly all situations it is substantially cheaper for local authorities to place people in residential care, even where there is no difference between the gross cost of residential care and care at home.[77] The Audit Commission report found that, in the sample of local authorities visited, the net cost to the authorities (after taking account of charges to individuals) of providing a domiciliary care package assumed to cost £197 per week would range, for someone on income support, from £137 to £197. This is substantially more than the net cost of a place in an independent residential home (assumed to have a similar gross cost of £197 per week) which would be £94. For someone with a 'middle income' and savings, the range for the net cost to the local authority of a domiciliary package assumed to cost £197 was £100 to £186, compared to a net cost to the authority of £28 for residential care.[78] This is because of the discretionary nature of the regulations governing charges for domiciliary services, particularly with regard to the treatment of savings and property, which

[76] For further information see *Community Care, Findings from Department of Health Funded Research 1988-1992*, DoH, 1993.

[77] *Balancing the Care Equation: Progress with Community Care*, Audit Commission Community Care Bulletin Number 3, March 1996.

[78] Ibid.

leads local authorities to develop their own charging systems for domiciliary care services.[79] The discretion permitted in relation to domiciliary care contrasts with the situation in respect of residential care, where local authorities must apply a nationally determined means-test.

46. Taking capital into account when setting charges potentially reduces the perverse incentive to use residential care, but the Audit Commission point out that those with low incomes could find it hard to pay for domiciliary care if their capital is in the form of their own home. There is also a case for questioning whether the value of the home should be taken into account when assessing charges for domiciliary care services — but if the value of the home is excluded this leaves a perverse incentive to use residential or nursing home care. The Audit Commission also state that there is uncertainty about whether local authorities have the powers to impose domiciliary care charges in this way.[80] The Health and Social Services and Social Security Adjudications Act 1983 allows local authorities to recover such domiciliary care charges as they consider reasonable, but the charge levied has to be no more than it appears reasonably practicable for the user to pay. The Audit Commission comment that the extent and limits to 'reasonableness' are not known. **It is crucially important that the charging system should not contain perverse incentives for local authorities to steer individuals towards residential rather than domiciliary care (or indeed, for that matter, for individuals to opt for homecare on financial grounds if this is not in their own best interests).**

Rehabilitation services

47. In our earlier report, we called for greater emphasis to be placed by the NHS on rehabilitation services, and urged the DoH to "ensure that sufficient numbers of trained therapy staff are available to meet the likely increase in the demand for them as the NHS reappraises the priority it gives to purchasing rehabilitation services".[81]

48. The Government's reply, issued in January 1996, stated that "consideration of the need for rehabilitation, whether to prepare the patient for discharge or aimed at recovery or maintenance in the community, should be an integral component of any assessment of a person with continuing care needs and should be included in their agreed care package".[82] This was an issue the DoH would look at closely in its monitoring of progress in implementing the long-term care guidance. With regard to availability of trained therapy staff, the Government stated that this was a matter for employers, but that the local workforce planning consortia to be set up in April 1996 would have the responsibility of ensuring that staffing levels — including those for occupational therapists and physiotherapists — were sufficient to meet future demand for services. In addition, a Joint Strategy Group on Local Authority Occupational Therapy Services had been established with representation from DoH, local authority associations and professional bodies, and a remit to secure improvements in the delivery of community occupational therapy services; and the DoH monitored training figures to ensure that employers' stated needs for qualified speech and language therapists were met.

49. **Evidence taken in the second phase of our inquiry further supports our view that a shift in thinking towards rehabilitative solutions is desirable.** The Association of Directors of Social Services (ADSS) argued that much of the recent public debate had inappropriately focused on institutional solutions and had "ignored the health promotion [and] rehabilitative potential of long-term care in the promotion of dignity, self-worth and inclusion in citizenship".[83] They also told us that "the role of rehabilitation in not only creating independence but reducing long-term care demands has considerable undeveloped potential".[84] They cited a number of joint health/local authority initiatives, particularly in

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[79] Ibid.

[80] Ibid.

[81] HC 19-I, para 37.

[82] Cm 3146, p3.

[83] Ev. p131.

[84] Ev. p141.

the South-West of England, which they claimed were demonstrating "that people can be appropriately discharged home after major surgery followed by slow-stream multi-disciplinary rehabilitation, with levels of community health and social care not greater than they were receiving prior to the trauma and subsequent hospitalisation".[85] The ADSS said that they were collaborating with the Social Services Inspectorate in further examining the potential of these models.

50. The British Geriatrics Society claimed that "massive savings can be achieved through effective pre-admission assessment and rehabilitation".[86] They submitted hypothetical examples suggesting that savings of up to £10 million annually could be achieved in respect of each average group of 1,000 older people currently being considered for long-term care. The economic model employed, developed by Professor Peter Millard, President of the BGS, and based on patient flow at St George's Hospital, Tooting, indicated that the benefits of improved assessment and intervention increase up to the level of 60% of patients, after which diminishing returns set in.[87] Dr David Black, representing the BGS, told us that "if you get the right amount of assessment and rehabilitation, not too little and not too much, the right amount, there are considerable overall savings in preventing people having long-term care who do not need it".[88] The BGS called for improvements in pre-admission assessment procedures by providing for specialist medical leadership, and for an increase in facilities and in the number of hospital beds to provide for more specialist rehabilitation.[89]

51. Ms Pauline Ford of the Royal College of Nursing told us that nursing research in London and Oxfordshire suggested that "if you do provide rehabilitation you can discharge people from continuing care beds much more quickly with much more positive outcomes for the quality of life and the independence of the old people".[90]

52. The former Parliamentary Under-Secretary, Mr Bowis, said that he "very much agree[d]" with witnesses who had expressed concern about the unnecessary institutionalisation of many elderly people and who had claimed that greater investment in rehabilitation and preventive measures would also save money by reducing the overall need for long-term care. He said that "rehabilitation is increasingly going to be seen as a contribution to enabling people to benefit from the care that they need so that it becomes a step towards something else and not just an end in itself".[91] When questioned as to whether research had been commissioned into the cost-effectiveness of rehabilitation, Mr Bowis said that this might well be looked at within a four-year programme of research shortly to be undertaken into the care of the elderly, at a cost of some £2.4 million. The DoH later gave us further details of the programme: it will be a study of community health services, commissioned by open competitive tender, and will include "research on the cost-effectiveness of providing preventive care through early interventions, and on other aspects of long-term care".[92] Mr (now Sir) Herbert Laming, Chief Inspector of the Social Services Inspectorate (SSI), added that the frequently observed fact that people tended to be going into nursing homes in their eighties rather than, as in previous years, in their seventies, indicated that rehabilitation schemes and other measures to support people in the community were steadily being put in place.[93] We are not, in fact, convinced that this trend of later admission to nursing homes necessarily indicates a greater use of rehabilitative measures; it could well arise simply as a result of general improvements in the health of elderly people.

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[85] Ibid; see also Q421.

[86] Ev. p129.

[87] Ev. pp128, 163.

[88] Q419.

[89] Ev. p128.

[90] Q421.

[91] Q800.

[92] Q801; Ev. pp396-399.

[93] Q801.

53. The Social Services Inspectorate (SSI) has recently published a booklet and video encouraging local authorities to consider establishing short-stay 'social rehabilitation' schemes to enable older people to return to their own homes after a stay in hospital, instead of going into long-term residential care.[94] Such schemes, typically based in adopted residential care homes, are currently operated by four local authorities in England: Devon, Dorset, Hampshire and Kirklees. According to the SSI, the schemes have six key elements in common:—

"• the elderly people who are cared for would otherwise have had to go into long-term residential care

• they remain in the rehabilitation unit for about six weeks

• when they leave, the cost of their care needs is low

• rehabilitation is an active process geared towards activating people and restoring their confidence with input from skilled staff

• there are benefits to clients and their carers

• there are benefits for budgets both in health and in social services."[95]

54. The majority of clients are referred directly from hospital — often having suffered a serious medical incident such as a stroke or amputation — and in over 70% of cases were able to return to their own homes after a short period of rehabilitation. The SSI describe the schemes' results as "remarkable", enabling "the great majority of their clients to return home, generally with an increased level of independence".[96] One of the schemes, that at Outlands Resource Centre in Plymouth, supplied us with a cost-benefit analysis undertaken after the pilot project for the scheme which ran from September 1992 to February 1993. This took the average unit cost of £327 per resident per week, added the cost of the domiciliary care they needed when they went home, and compared the total with the likely cost if the clients had been discharged direct from hospital into residential care. It was calculated that the average saving per person was about £750 per person in February 1993; ten weeks later this had risen to nearly £2,000.[97]

Rehabilitation: Conclusions

55. **We wholly agree with the ADSS that the recent public debate about the future of long-term care has placed too much emphasis on institutional solutions and has downplayed the potential of rehabilitative services. We repeat the call we made in our earlier report for the NHS to place greater emphasis on rehabilitation, domiciliary and health promotion services. It is perhaps not unreasonable that in the three years following local authorities' assumption of additional responsibilities in April 1993, they should have directed most of their managerial effort at the commissioning and purchasing of residential and nursing-home places. Henceforward, however, they should show more flexibility in their provision of care packages, and we recommend that the DoH should take steps to encourage them to do so. In particular, we believe that all local authorities should be asked to give serious consideration to the setting up of social rehabilitation schemes along the lines of those to which the SSI has drawn attention. We believe that authorities should seek to purchase an increasing number of short-term rehabilitative services and respite care services from local care providers, both public and private. We also believe that necessary measures should be taken to preserve people's rights of access to their own home for a reasonable time after entering care.**

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[94] *The Key to Independence: Social Rehabilitation Schemes for Older People*, DoH Social Services Inspectorate, February 1996; unpublished memoranda (LTC 143 and LTC 144).

[95] Ibid., p3.

[96] Ibid.

[97] Unpublished memorandum (LTC 144, pp8, 12-13).

Housing Services

56. For long-term care services to meet effectively the needs of those requiring care, there has to be close collaboration between social services departments and housing authorities. Professor Anthea Tinker of the Age Concern Institute of Gerontology at King's College London, commented that "housing has been the great neglected part of community care".[98] Her views were supported by Mrs Evelyn McEwen of Age Concern who said that "one of the missing links in the development of community care is the involvement of the housing authorities."[99]

57. Professor Tinker pointed out that the prospect of long-term care being provided in a person's own home depends not only on the availability of domiciliary care services but also on the suitability of the home itself. She argued that the aim in the long-run should be to build homes that are suitable for people of all ages and disabilities, and that in the meantime the provision of aids and adaptions to existing homes was essential.[100] Professor Tinker highlighted a number of areas where improvements in housing policy and practice were needed. These improvements would include good care and repair schemes; alarm schemes; smaller, more easy-to-manage accommodation; and 'very sheltered' housing schemes.[101] She argued that ordinary sheltered housing schemes (where all that is provided is communal areas and a warden who is not necessarily present at all times) were of little use to people who were frail.[102] Mr Peter Fletcher of Anchor Housing, a national housing association and care provider specialising in services to older people, expressed similar sentiments when he agreed that there was scope for many housing authorities to convert traditional sheltered housing units into very sheltered schemes.[103] He went on to say that Anchor were keen to promote a wider range of housing services to their residents and that "to be honest, unless sheltered housing is shifted in that way, then it will have a negative image of an outdated product on a sort of a declining spiral".[104]

58. Anchor Housing told us that the role of housing in long-term care was crucial, and emphasised the need to bring housing services into the centre of long-term care planning.[105] They outlined a number of schemes that they are involved in around the country, in partnership with health and local authorities. These aim to ensure that people can remain in their own homes, through the use of housing improvement grants and housing adaption schemes, and it appears they can reduce the demand for long-term care.[106] Anchor did, however, comment adversely on the amount of effort that they had to put into getting such schemes off the ground, with individual projects at risk of failing to come to fruition due to conflicting priorities on the part of the health and social services purchasers.[107]

59. A study published in 1992 by the Social Policy Research Unit at the University of York into the provision of community alarm schemes found that such schemes were the only organised social care services available to people living in ordinary housing who were most likely to need to call for urgent assistance. The researchers noted that the absence of urgent help and a means of calling for it can threaten older people's ability to manage at home, inhibiting community care policies. They stated that Community Alarm Schemes typically comprise three elements:—

- a telephone alarm unit, activated from anywhere in the home by a small portable device, which allows the user to talk with a special operator;

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[98] Q350.
[99] Q303.
[100] Ev. p389.
[101] Q350.
[102] Ibid.
[103] Q601.
[104] Q602.
[105] Ev. p196.
[106] Q569-575.
[107] Q575.

- a control centre staffed by operators who assess need and appropriate action; and
- people with access to keys who have agreed to visit the caller urgently (many services employ mobile wardens, others rely on individuals known informally to the users, and a few involve volunteers recruited from voluntary organisations).[108]

60. The research found that whilst most local authority housing departments in England and Wales offered some form of alarm service, only a small number of social services departments and health authorities were involved in such schemes. Our predecessor committee, the Social Services Committee, visited in 1988 one such scheme, the Fife Community Alarm Scheme. This was operated jointly by the Social Work Department of Fife Regional Council, the housing departments of three district councils and Glenrothes New Town, together with Scottish Homes and the Fife Health Board. We understand that our predecessors were very impressed with the scheme's objectives and the services it provided. Community Alarm Schemes are a fine example of a socially beneficial initiative which is also cost-effective, because the timely provision of assistance to an old person who has had a fall or a sudden medical emergency at home will frequently obviate the need for more costly interventions at a later stage.

61. The former Parliamentary Under-Secretary, Mr Bowis, told us that he wanted to see more and better co-ordination between housing and other authorities. To this end, he said, the DoH and the Department of the Environment (DoE) were currently consulting interested parties on proposed joint guidance on housing and Community Care.[109] Mr John Belcher of Anchor Housing told us that unless "there is a direct link between community care plans and housing investment strategies which actually carry some stick as well as some carrot" he felt that there would difficulties in encouraging housing authorities to use their housing stock more creatively.[110] Professor Tinker told us of recent evidence that suggested that both housing departments and housing associations were still being left out of community care planning arrangements, although she pointed out that there had been improvements in such arrangements over the last two or three years.[111]

62. Mr Peter Fletcher of Anchor Housing told us that it was not always the case that the policies of the DoH and DoE in respect of community care were properly integrated at the national level. He gave as an example the proposals in the Housing Bill which has been before Parliament this Session, to remove mandatory grants for home improvements and reduce the level of funding for local authorities to provide home improvement grants.[112] He argued that it was well known that improved housing conditions, such as better insulation, directly impact on health.[113] Mr Martin Shreeve of the ADSS told us that he thought there should be "considerably more investment by local authorities, social services departments as well as central government, in grant-in-aid for property adaptions."[114]

63. We agree with those of our witnesses who felt that housing services are often a neglected part of the community care framework. Housing improvements can offer a happy conjunction of cost-effectiveness for the providing authorities with improved quality of life for those who inhabit the housing. The DoH, in conjunction with the DoE, should take vigorous steps to ensure that housing services fully exploit their potential for contributing to the Government's community care objectives, particularly with regard to the development of very sheltered housing schemes and ensuring that ordinary sheltered housing schemes are attractive to the current and future generations of users. The DoH and the DoE should encourage the wider development of collaborative schemes

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[108] *Community Alarm Schemes for older people*, Joseph Rowntree Foundation Social Care Research Finding No.22, May 1992.

[109] Q810.

[110] Q602.

[111] Q353.

[112] Q629.

[113] Ibid.

[114] Q457.

such as community alarm schemes like that operated in Fife and elsewhere. The benefits to be obtained from these and other improvements in housing provision should be taken fully into account as an integral part of future care plans at both local and national level.

Liaison between health authorities, social services departments and housing agencies

64. As we have seen in the preceding paragraphs, the effective provision of care depends crucially upon adequate liaison between the various agencies responsible for different aspects of its provision. Some of our witnesses argued that the current arrangements whereby local authorities, health authorities and housing agencies are all involved in managing and planning long-term care services creates a situation in which there are incentives for each type of authority to seek to shift the burden of care either for an individual, or for a group of clients, on to the other authorities. The British Nursing Association told us that there were financial incentives for authorities not to co-operate, and that these could lead to 'grey area' services not being provided at all.[115] The ADSS expressed similar concerns over the impact of 'cost-shunting' by both health and local authorities.[116]

65. One of the contributory factors to the success of the Intensive Homecare Scheme we visited in Belfast is undoubtedly the way it is run by an integrated authority covering both health and social services. On being questioned as to whether it would be possible to operate such a scheme in England, the former Parliamentary Under-Secretary, Mr Bowis, replied that he thought it would be, because

> "the relationships between health and social services have been transformed by Community Care. People talk to each other, they plan together, not just health and social services, they bring in the providers in the independent sector, they bring in the users of the services and their families as well in all the planning of services. There is a great deal more now taking place than used to be the case."[117]

Mr Bowis cited as an example of good practice "some of the Hospital at Home schemes which bring together the hospital and the primary health care services and indeed the social services as well".[118]

66. It is reasonable to expect that conflicts between health and local authorities will be reduced as a result of the recently imposed requirement that the NHS should establish continuing care policies and eligibility criteria, although this will of course depend on the extent to which health and local authorities work together effectively in planning and agreeing those policies and criteria. In response to a recommendation in our earlier report, the DoH has published the conclusions it draws from its monitoring of health and local authorities' progress in developing and implementing policies and criteria.[119] **The DoH expresses concern that some health authorities have proposed eligibility criteria which could operate over-restrictively. We share that concern, and look to the DoH to ensure, through their ongoing review and monitoring programme, that this does not happen. We look forward to receiving regular future reports from the DoH on the implementation of the policy. With regard to other areas of interaction between agencies, we have expressed above our belief that schemes similar to the Intensive Homecare Scheme in Belfast *could* operate successfully in England. Nonetheless, the existence of separate authorities responsible for separate functions does, at the least, act as a disincentive to such initiatives and to the seamless provision of services. Whether there is a case for unitary authorities in England along the lines of those in Northern Ireland is too large an issue to be encompassed within the present report, although it is one to which we or our successors in the next Parliament may wish to return.**

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[115] Ev. p351.

[116] Ev. pp132-134.

[117] Q786.

[118] Ibid.

[119] Unpublished memorandum (LTC 9X), and DoH Executive Letter, EL (96)8, *NHS Responsibilities for meeting continuing health care needs - current progress and future priorities*, February 1996.

Perceived Unfairness and Anomalies in the Current System of Financing Long-Term Care

67. Long-term care is an expensive service both for the taxpayer and for any individual contributing towards the cost of his or her care. Concerns over costs are augmented by concerns over the equity of the current arrangements.

68. The perceived unfairness of those arrangements was a theme raised by many of our witnesses. **In our previous report we commented in some detail on the implications of allowing health authorities to set local criteria for eligibility to receive free, NHS-funded, long-term care. We argued that these local criteria might create inequity, with individuals in some parts of the country receiving free NHS care whilst others in identical circumstances elsewhere had to contribute towards the cost of care commissioned by local authorities.[120] While recognising that the DoH's recent guidance represented a step in the right direction, we called for the national framework to include *national* eligibility criteria "to define what the NHS, as a national service, will always provide".[121] We are still of this view.**

69. If the public came to feel that there were significant variations in access to free NHS-funded long-term care, this could undermine confidence in the overall fairness of the health and welfare system. As Voluntary Organisations involved in Caring in the Elderly Sector (VOICES) told us:—

> "It is clear that there will only be equity in provision and clarity about responsibility if eligibility criteria are centrally determined. Access to services must be dependent on need not on geography."[122]

70. In addition to variations in *access* to care, there appear to be also significant local variations in the *provision* of care. Recent data published by the DoH shows the average number of local authority supported residents in residential and nursing homes per 1,000 resident population aged 75 and over in each local authority area as at 31 March 1995.[123] On average, local authorities supported 34 residents in nursing or residential home care per 1,000 population aged 75 and over. Seven per cent of authorities were supporting more than 51 residents per 1,000 population, and four per cent supported fewer than 17 residents per 1,000 population. The variations in the proportion of local authority supported residents specifically in nursing homes were much greater. On average, local authorities supported 9.3 residents in nursing homes per 1,000 population aged 75 and over. Twenty-three per cent of authorities supported more than 14 residents per 1,000 population, and 13% fewer than 4.6 residents (with four authorities shown as not supporting any residents in nursing homes). These figures do not take account of the fact that some areas will have elderly populations with greater need of care, nor of variations in the other health and local authority services that might be available locally to keep people out of nursing homes until absolutely necessary. Nevertheless the variations between individual authorities are surprising, particularly for nursing home care.

71. Some of our witnesses criticised the current system of means-testing state-supported residents in residential or nursing homes as inequitable on a further ground, namely that it penalised those people who had saved during their working life, while rewarding with free care those who had been unable, or unwilling, to save. The Continuing Care Conference told us that means-testing was perceived as "grossly unfair by the thrifty, represent[ing] both a disincentive to save and a challenge to those able to divest themselves of capital."[124] Mr William Laing of Laing & Buisson commented that the divide between free and means-tested care means

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[120] HC 19-I, paragraphs 47-50.

[121] HC 19-I, paragraph 51.

[122] Ev. p330, para 2.1.

[123] *Official Report*, 14 February 1996, *c598-602w*.

[124] Ev. p313.

"that there is a sense of unfairness between the person who has been frugal throughout his or her life, who has to pay; ... and the spendthrift in the room next door who has spent all his or her money on wild living, and who gets exactly the same service paid for by the State".

Mr Laing added that such a sense of unfairness arises as an inevitable consequence of any system of means-testing (a comment which would apply, of course, to other social security benefits as well).[125]

72. Many witnesses told us that they felt that the balance between the individual and the State had been shifted, and that an implicit promise by the State — to provide care 'from the cradle to the grave' — had been broken. This opinion was expressed in many forms. The Greater London Pensioners Association claimed that all pensioners "resented the *de facto* reneging on the social contract ... of care from the cradle to the grave in return for a lifetime of paying taxes."[126] A similar point was made by Mr Richard Thomas of the ABI, who told us that the typical buyers of long-term care insurance products were those in the over-60s age group:

"who during their lifetime had an expectation that the state would provide because during their lifetime the welfare state, for instance, provided a much larger number of long-stay beds in NHS institutions. I think that element of society feels, perhaps, that it has had the rug pulled [from] beneath it." [127]

73. Mr Thomas's comments were echoed by the Prudential Assurance Company, which commented that there was a "public mind-set", particularly amongst older generations, that the Welfare State which they had supported through their taxes and national insurance should be responsible for providing long-term care.[128]

74. The Joseph Rowntree Foundation have recently commissioned research from Social and Community Planning Research on the public's views and perceptions on options for financing long-term care for older people. This research found that the current system was generally regarded as being injust in that:—

"
- people felt that they had been given a false promise by the State that long-term care would be provided free at the point of delivery;
- means-testing... was felt to be unfair because... thrifty individuals.... would have to pay towards their care, whilst the spendthrift would be eligible for state funding;
- the £8,000 threshold [the research was conducted prior to the recent increase] was.... too low;
- the idea of being forced to sell their homes to pay for care caused great distress amongst people. This was partly because they hoped to leave it to their children as their largest financial resource, for many it also represented an asset which they had worked hard to achieve;
- it was widely felt that nursing care for older people should be provided free..... people were angry that such care was no longer free to all those who needed it; and
- there was some objection to local authorit[ies] charging for domiciliary care services."[129]

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[125] Q200.

[126] Ev. p347.

[127] Q75.

[128] Q506.

[129] *Meeting the cost of continuing care: public views and perceptions*, Social Care Research Finding 84, Joseph Rowntree Foundation, April 1996.

75. On the other hand, the Nuffield Community Care Studies Unit at the University of Leicester argued that "serious questions" had to be raised about whether it was right that the younger generation "should expect to inherit capital in the form of housing (the purchase of which will have been subsidised by the State in part) *and* expect the State to pay for the care that their parents might need".[130]

76. There is no doubt that many members of society, particularly from the older generation, genuinely feel that the State has reneged upon an implicit undertaking to provide long-term care when they are in need. It has nevertheless been the case throughout the history of the welfare state that the State has means-tested those people requiring residential social care. Why then is there such disquiet about the current arrangements? We think that there are a number of factors at work here. First, for the reasons set out in our earlier report,[131] we consider that there has been a shift in the boundary between NHS and social care, caused by the expansion of private-sector nursing homes during the 1980s, financed by means-tested social security money. This has gradually created a situation in which general, as distinct from specialist, long-term nursing care is no longer considered to be an NHS responsibility but rather as social care and thus eligible for means-testing. These changes were formalised in the NHS and Community Care Act 1990 which gave social services departments the responsibility for purchasing general nursing home care. Secondly, people are, on average, living longer, and therefore more people are arriving at the stage in life where they are likely to need long-term care. Finally, society as a whole has become wealthier, and the substantial increase in the numbers of elderly people owning their own homes means that many people now have assets significantly above those specified in the means-testing thresholds (even after the recent increases in the thresholds). The General Household Survey found that by 1993 the proportion of people aged 60-69 who were owner occupiers had risen to 70%.[132] Owner-occupation among the over 65s rose from 44% in 1975 to 54% in 1991.[133]

77. Compounding the effect of these changes has been a strong desire amongst the older generation to pass on an inheritance to their children or dependents. Companies who offer long-term care financial products told us that a prime motive for many of their customers in buying these products was a desire to protect inheritances.[134] Age Concern also told us of a huge upsurge in inquiries they have received for copies of a briefing paper they produce outlining the advantages and disadvantages of transferring individuals' assets early to their intended heirs.[135] Age Concern stated that between October 1994 and March 1995 they received 800 inquiries, between March 1995 and October 1995 they received 4,000 inquiries, and by November 1995 inquiries were running at the rate of 1,000 per month.[136] It is clear that people are becoming more aware of the possibilities of transferring their assets to avoid having to contribute towards the cost of their social care.

78. **It must be a matter of concern that many members of the public believe that there has been a deliberate change in the rules governing payment for long-term care. In relation to residential care, the former Parliamentary Under-Secretary of State, Mr Bowis, told us that this is not actually the case.[137] Whether it can fairly be said that the rules regarding payment for nursing home care have not altered is more open to question: as we commented in our earlier report, many people who are now cared for in nursing homes on a means-tested basis would in previous decades have been cared for by the NHS without charge.[138] Later in this report we discuss possible changes to the funding arrangements for nursing-home care which might go some way towards meeting current concerns about payment for long-term care.**

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[130] Unpublished memorandum (LTC B5A, p9).

[131] HC 19-I, para 28.

[132] Ev. p270.

[133] *Inheritance in Britain: the boom that never happened*, PPP Lifetime, 1995.

[134] See for example, Ev. pp4-5.

[135] *Cascade or care? Implications for the future of the transfer of assets*, Age Concern England, November 1995.

[136] Q298.

[137] Q746-47.

[138] HC 19-I, para 18.

79. While we accept that the desire to pass on an inheritance is an understandable one, it can also be argued that one of the purposes of saving is to save for one's retirement and for unpredictable events. For that reason there is a strong argument that the State should take savings, as well as income, into account when assessing the contribution that individuals should make towards the cost of the residential and domiciliary care services arranged by local authorities, which have always been subject to a means test. Indeed, those individuals' fellow tax-payers might feel justifiably aggrieved if this was not the case. However the situation is complicated by the fact that for many people the majority of their saved wealth takes the form of a housing asset, and although strictly speaking this is no different from any other form of asset, in psychological terms it *is* different: people think of the house they live in as their home, rather than as an asset in the same way that savings are assets. The fear of losing one's home is compounded by the present difficulty of making use of *part* of the wealth represented by a housing asset: this an area where equity release schemes, which we discuss later, may represent the way forward.

80. In our view it is neither equitable nor desirable to create a system which guarantees that *all* assets will be safeguarded for inheritors in *all* circumstances. Nonetheless, policy-makers need to take account of the way patterns of provision, demands upon the State, and public expectations have altered in recent years, and of the widespread perception that the present arrangements for funding long-term care are unfair. In a later section of this report we will consider a range of proposals for addressing these problems.

III — THE CHANGING CONTEXT

81. In this section of the report we review the changing context within which long-term care services need to be reviewed and planned. We consider three key elements that will affect the likely demand for such services: demographic trends, trends affecting the supply of informal care, and possible changes in the health status of elderly people.

Demographic Trends

82. Nearly every submission we received drew our attention to the potential impact of projected demographic trends. The latest projections from the Government Actuary's Department, which are regarded as reasonably robust, indicate that the population of the UK will continue to increase over the next 27 years, rising by 4.7% from 58 million in mid-1994 to over 61 million by 2023. It is then projected to start falling to around 54 million by 2061.[139]

83. However, within these overall totals there is a shift towards a markedly older population. Table 3 indicates that the proportion of the population of the UK aged 65 and over will increase from 15.7% in 1994 to 16.4% in 2021, and 25.6% by 2061. The growth in the numbers of those aged 85 and over (who typically make most use of long-term care services) is even more pronounced, with a near tripling in absolute terms from 1994 to 2061. People aged over 85 comprised 1.7% of the population in 1994 but are projected to comprise 2.3% in 2021 and 4.8% in 2061.[140]

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[139] Government Actuary's Department, *Population Projections, 1994-2064.*

[140] Ibid, Table 7.2 and Appendix I.

Table 3: Projected changes in the age-structure in the UK population: 1994-2061

Age Group	1994	2001	2011	2021	2031	2041	2051	2061
All Ages	58,395	59,472	60,493	61,130	60,720	59,042	56,656	54,015
0-14	11,359	11,291	10,405	10,125	9,798	9,118	8,782	8,417
% aged 0-14	*19.5*	*19.0*	*17.2*	*16.6*	*16.1*	*15.4*	*15.5*	*15.6*
15-64	37,850	38,933	40,181	39,258	36,819	35,061	33,697	31,749
% aged 15-64	*64.8*	*65.5*	*66.4*	*64.2*	*60.6*	*59.4*	*59.5*	*58.8*
65-74	5,223	4,864	5,393	6,560	7,677	7,058	6,312	6,637
% aged 65-74	*8.9*	*8.2*	*8.9*	*10.7*	*12.7*	*11.9*	*11.1*	*12.3*
75-84	2,954	3,225	3,235	3,789	4,660	5,589	5,096	4,632
% aged 75-84	*5.1*	*5.4*	*5.4*	*6.2*	*7.7*	*9.5*	*9.0*	*8.5*
85+	1,011	1,158	1,281	1,397	1,767	2,216	2,768	2,579
% aged 85+	*1.7*	*1.9*	*2.1*	*2.3*	*2.9*	*3.8*	*4.9*	*4.8*

Source: Government Actuary's Department, *Population projections, 1994-2064.*

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84. While these projected increases are large, they should be set in context. Between 1994 and 2021 the number of elderly people aged 85 and over is projected to increase by around 400,000 — this is actually a *smaller* increase in absolute terms than that which occurred between 1971 and 1994 when this group of the population rose by over 540,000.[141] It is also worth remembering that population projections are not statements of fact about how the population will change over time, but are best estimates based on the information available at the time of the projection. Compared to the previous national population estimates, which were based on estimates of the UK population in 1992,[142] the latest estimates shown in Table 3 show fewer people aged 85 and over for the period of the forecast, while the numbers of people aged 65-74 are higher until around 2021, after which they follow the same trend as for those people aged 85 and over.

85. Apparently small shifts in the percentage of people in different age groups may have a disproportionate effect in terms of public expenditure. The very elderly, like the very young, require significantly more NHS care, as the following table demonstrates:

Table 4: Age Bands and Expenditure per Head

Age Bands	Expenditure per Head Average 1992-93
Births	1,762
Band 1 (0-4)	374
Band 2 (5-15)	185
Band 3 (16-44)	241
Band 4 (45-64)	355
Band 5 (65-74)	703
Band 6 (75-84)	1,280
Band 7 (85 plus)	2,261

Source: Second Report from the Health Committee, Session 1995-96, *Allocation of Resources to Health Authorities*, HC 477-I, Table 3.

86. Another important factor in determining the overall affordability to the nation of long-term care is changes in the dependency ratio. This ratio represents the number of children under sixteen or the population of pensionable age (or the sum of the two) expressed as a percentage of the working population. The latest projections from the Government Actuary's Department indicate that the total dependency ratio will fall gradually from 64 dependents per 100 persons of working age in 1994 to 60 dependents per 100 persons of working age by 2006. After this the dependency rises to 67 dependents per 100 persons of working age by 2021, reaching a plateau of around 80 dependents per 100 persons of working age after 2031. These figures do not take account of the increase in women's retirement age, which is to be phased in between 2010 and 2020, and which will reduce the dependency ratio. The pensionable age ratio follows a similar trend and is projected to remain fairly stable until 2020, but then to rise rapidly over the next 20 years.[143]

[141] Table 1; Laing & Buisson, *Care of Elderly People Market Survey 1996*, Ninth Edition, Table 1.1.

[142] OPCS, *1992-based National Population Projections*, Appendix I.

[143] Government Actuary's Department, *Population Projections 1994-2064*.

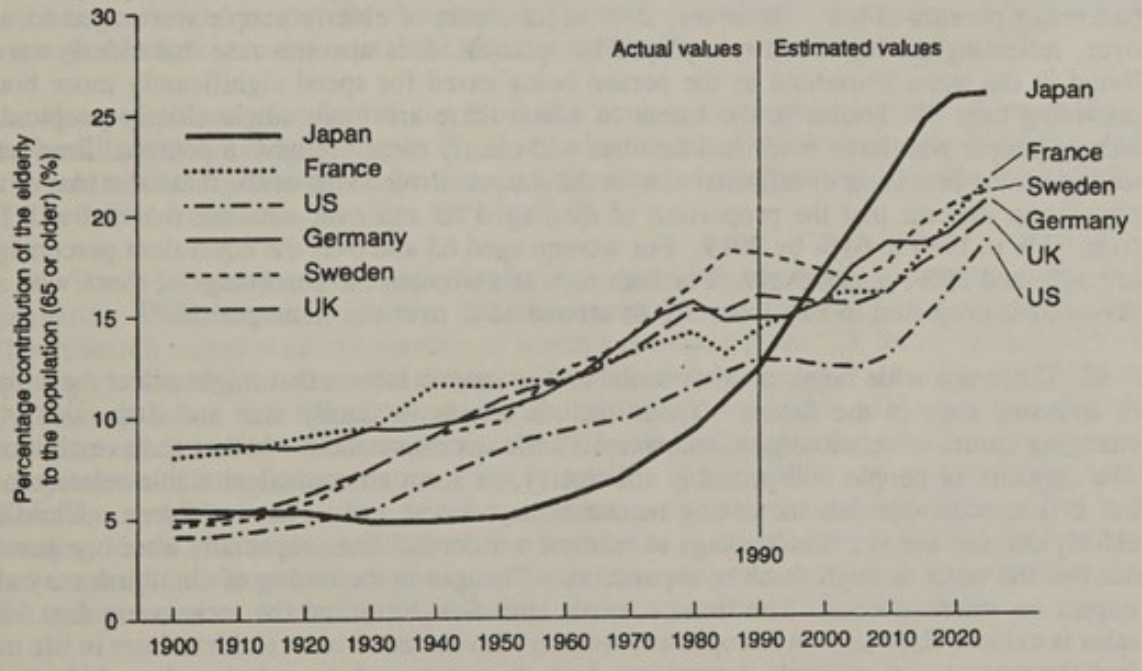
87. The projected long-term increases in the UK's population are in line with or in some cases smaller than those projected for other developed countries. In Germany, the number of people aged 60 and over is estimated to increase by 55% by 2030, and their share of the total population to increase from just over 20% to around 35%.[144] The dependency ratio (ratio of over-65s to 15-64 year olds) is forecast to rise from less than 24% in 1990 to 47% in 2040.[145]

88. In Japan the projected increases in the numbers of the elderly and their proportion within the population are even greater, thus creating what is referred to as the "silver society". Japan now leads the world in terms of longevity with an average life expectancy of 80 years.[146] The current population is some 125 million; this is projected to rise slightly to 130 million by 2010, then to fall to close to its present level before declining to 111 million by 2050.[147] The proportion of the population aged 65 and over is projected to increase from its present level of 14.5% to 25.5% in 2020, and rise slightly thereafter to 28.2% in 2050.[148] The number of elderly people needing long-term care is estimated to increase from 2.0 million in 1993 to 5.2 million in 2025.[149]

89. The following chart and table set out the Japanese Health Ministry's estimates of the proportion of the elderly within the population in advanced Western countries and Japan over the next 35 years. It will be noted that of the six countries chosen, the estimated increase for the UK is the second lowest.

Figure 1

Percentage Contribution of the Elderly to the Overall Population in Advanced Western Countries and Japan



[144] Confederation of German Employers' Associations, *Social Provision in Germany: The Welfare State at the Crossroads*, trans. Andrew Jackson (Cologne, 1994), p5.

[145] HBM Embassy, Bonn: private briefing for Committee.

[146] Ministry of Health and Welfare of Japan, Health and Welfare Bureau for the Elderly, *New Gold Plan (Strategy to Promote Health Care and Welfare for the Elderly)* (Tokyo, 1995), p2.

[147] Health and Welfare Statistics Association of Japan, *Health and Welfare Statistics in Japan 1995* (Tokyo, 1995), pp18, 20.

[148] Ibid., p20.

[149] Ibid., p3.

Table 5: International Comparison of Elderly Populations

Country	Percentage contribution of the elderly to the population (65 or older) (%)			
	1950	1990	2000	2020
Japan	4.9	12.0	17.0	25.5
US	8.1	12.5	12.4	16.1
UK	10.7	15.7	15.3	18.0
Germany	9.7	15.0	16.0	20.9
France	11.4	14.0	15.7	19.7
Sweden	10.3	17.8	16.7	20.7

Source: New Gold Plan, p2. Figures for Western countries from United Nations, *The Sex and Age Distribution of World Populations* (1994). Values for Germany are for a unified Germany.

Social Trends and Other Factors affecting the Supply of Informal Care

90. Many witnesses commented on the vital role provided by 'informal' carers, i.e. relatives and dependants who provide long-term care on an unpaid basis. As we noted in paragraph 11 above, the majority of care is provided informally. Concerns have been expressed that changing social trends may in fact reduce the potential supply of informal care. Mr Stephen Nuttall of the Institute and Faculty of Actuaries told us that a substantial amount of informal care is provided by spouses and that in a society where divorce is increasingly prevalent, there will be an increasing number of single individuals moving into old age.[150]

91. Supplementary analysis of the 1990 General Household Survey has revealed that the peak age range for caring is 45-64, reflecting children (mainly women) caring for elderly parents or parents-in-law. However, 20% of all carers of elderly people were aged 65 and over, reflecting the important role played by spouses. It is also the case that elderly carers living in the same household as the person being cared for spend significantly more hours providing care.[151] Trends in the extent to which there are more single elderly people and elderly people who have never had families will clearly therefore have a potential long-term impact on the provision of informal care in the future. Projections of the marital status of the population indicate that the proportion of men aged 65 and over who are married will fall from 73% in 1989 to 61% by 2019. For women aged 65 and over the equivalent percentages are 38% and 35%, respectively. For both men and women, the percentage of those who are divorced is projected to rise from 3% to around 15% over the same period.[152]

92. There is a wide range of other social and economic factors that might affect the supply of informal care in the future. These include trends in family size and dispersion, the changing nature of relationships, and women's life decisions about whether to have children. The majority of people will probably still marry, or form an equivalent stable relationship, but it is conceivable that increasing numbers may choose not to have children. Childless elderly couples are at a disadvantage in relation to informal care, especially after one partner has lost the other through death or separation. Changes in the timing of childbirth may also impact on informal care. The trend towards later first birth and the increase in first birth rates is evident elsewhere in Europe, and women who decide to have children later in life may find themselves with multiple dependents, both the young and the elderly. Any shifts in the extent to which family dispersion increases could also have significant effects on care provision, as research has shown strong correlation between residential proximity and the frequency of visits to and from elderly parents.[153]

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[150] Q52.

[151] Lynda Clarke, *Family care and changing family structure: Bad news for the elderly?*, in Allen and Perkins, *The future of family care for older people*, HMSO, 1995.

[152] Ibid.

[153] Ibid.

93. It is possible that the increases which have occurred since the Second World War in the labour market participation rate for women may affect the ability or willingness of women to provide care. This is particularly significant in that it is women who provide the majority of informal care. However, there is evidence that caring activity by women has actually grown, alongside their increasing participation in the labour market. Women who are carers are almost as likely as others to be in paid employment. It has been argued that this combination of work and informal caring entails a major sacrifice of leisure time.[154]

Changes in Mortality and Morbidity

94. While people are undoubtedly living longer, there is debate as to whether the added years of life are years of good health or ill health. The most optimistic view of future morbidity trends was advanced by the researcher J. Fries in 1980 and is based on the concept of a fixed biological limit to the human life span. He argued that changes in health-related behaviour would mean that the onset of morbidity was delayed, while the age of death remained the same, resulting in a 'compression of morbidity'. In the near future, he claimed, the majority will enjoy a vigorous life until about the age of 85 and then die after a short period of ill health.[155] At the other end of the spectrum are those who argue that increasing life expectancy, coupled with existing morbidity patterns, will lead to people living longer with chronic health conditions.[156]

95. Mr Stephen Nuttall of the Institute and Faculty of Actuaries told us that while overall life expectancy is increasing, the evidence is unclear as to how much of this increased span would be spent in a healthy state.[157] Dr Emily Grundy of the Age Concern Institute of Gerontology told us that "very few people would accept the Fries hypothesis ... or ... the premises of his argument, many of which have been shown to be incorrect."[158] Dr Grundy told us that:

> "there is some uncertainty [over the health status of elderly people] but probably the consensus might be that the extent of very severe disability is decreasing slightly but the extent of slightly less severe disability or chronic illness may be increasing."[159]

She also pointed out that British and European work is hampered by a lack of good data on the health status of elderly people.[160] Similar comments were made by Mr William Laing, who told us that "quite frankly the data on both sides [of the argument over the 'compression of morbidity' hypothesis] is very, very bad".[161]

96. The DoH told us about work they have recently commissioned to examine methods of measuring health expectancy which combine mortality and morbidity in a single measure. This research included an examination of health expectancy in the UK for people aged 65 and over by considering trends in the ability of elderly people to perform activities of daily living (ADLs). It found that life expectancy with the ability to perform ADLs had increased for both men and women between 1976 and 1991, and suggested that, in the case of men, compression of morbidity *was* occurring in relation to their ability to perform these tasks. However, examination of trends based on a different data-set, dealing with self-reported long-standing illness, found that while there had been a rise in overall life expectancy for both men and women, in contrast health expectancy had remained almost constant, which would suggest that compression of morbidity might *not* be occurring. The DoH told us that:

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[154] Ibid.

[155] Dr Emily Grundy, Demographic influences in the future of family care, in Allen and Perkins, *op. cit.*

[156] Ibid.

[157] Q125.

[158] Q335.

[159] Q334.

[160] Q335.

[161] Q230.

"the projected picture therefore varies according to which types of data are used and may depend also on changes in people's expectations and habits of self-reporting".[162]

97. The DoH has commissioned an updating of this research to take account of 1994 data, and it has established a working party to consider the researchers' recommendations as to the data that should be collected in the UK to allow changes in health expectancy to be measured.[163] **Given the concerns expressed by many of our witnesses over the lack of robust data regarding the situation in the UK, we recommend that the DoH should ensure that further research on the health status of elderly people and the relationship between longevity and morbidity, taking into account the possible impact of healthier lifestyles, is commissioned and adequately funded.**

The Changing Context: Conclusions

98. **Population forecasts through to the middle years of the next century are in themselves relatively reliable. Unfortunately, the level of future demand for long-term care is dependent not only on the size of the elderly population but also, and crucially, on much more unpredictable factors such as the number of people living alone and the health status of the elderly. The latter itself depends on developments which cannot be foreseen such as the extent of medical progress and the degree to which healthier lifestyles are adopted. All attempts to calculate future demand towards the end of the lifetimes of those who are now young therefore contain an element of crystal ball gazing. A number of witnesses, including the former Parliamentary Under-Secretary, Mr Bowis, referred, using a statisticians' term, to an 'expanding funnel of doubt' when projecting so far into the future.[164] One thing clearly emerges from our evidence. This is that the demographic and dependency ratio trends do not bear out suggestions that major problems are looming in the short to medium term, by which we mean the period through to about 2020. After this period the trends may present more of a challenge. In the next section of our report we look at the implications of these calculations for the future costs of long-term care.**

IV — THE FUTURE COSTS OF LONG-TERM CARE

Projections of the Future Costs of Long-Term Care

99. A number of commentators and economists have produced estimates of what the future costs of long-term care are likely to be, over the next 30 to 40 years. **We preface our summary of these estimates by remarking again on the extreme difficulty of making reliable projections over such a long period of time, owing to the large number of variables that must be considered and a lack of evidence as to which way trends are moving for some key variables, such as the future incidence of disability amongst the current generation of middle-aged people.** The DoH outlined some of the questions involved, to which no certain answers can be given:

"
- how is the age composition of the elderly population likely to change in the future?
- as people live longer, will their added years of life be years of good health or years of infirmity?
- how will the cost of providing different types of long-term care alter over time?
- should we assume that family and friends will remain willing to provide informal care and to the same extent?

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[162] Ev. p262.

[163] Ibid.

[164] Q134, 790.

- as individuals are likely to have greater assets in future, is it likely that they will bear a greater proportion of the costs of long-term care?"[165]

100. **In the paragraphs which follow we outline some recent projections of the future costs of long-term care. We set these out in the interests of giving a full picture of recent public debate. We do not endorse any of the projections, and indeed we are very sceptical about some of them, particularly those which combine in what we think is a confusing way the *actual* costs of long-term care incurred by the State and by individuals, and the *imputed* costs of providing informal care (itself valued in these projections at £7 an hour, which is arguably too high a rate).**

(i) The Institute and Faculty of Actuaries

101. In 1993 a working party of the Institute and Faculty of Actuaries prepared a report which took a broad look at the future demand for long-term care and at possible financing mechanisms for the future.[166] The model estimated the prevalence of disability in 1991 by applying the results of the 1986 OPCS disability study to 1991 population figures and then projected these figures forwards under a number of assumptions regarding changes in the incidence of disability and morbidity.

102. The working party reduced the ten categories of disability identified in the OPCS study to four categories reflecting likely care needs: low (occasional), moderate (probably less than daily), regular (probably daily) and continuous. The report's central conclusion is that the number of disabled adults over 60 needing continuous care (i.e. the most heavily disabled as defined in the 1985 OPCS Disability Survey) could more than double from 482,000 in 1991 to 1,080,000 in 2031.[167] Mr Stephen Nuttall of the Institute explained that this conclusion took account of improved life expectancy, and assumed that individuals would spend part of their extra years of life in a healthy state and part in a state where they required care.[168] The large increase in the projected number of disabled adults needing continuous care was driven mainly by the increase in the proportion of over-85s in the population.[169]

103. The working party then took these projections and used them to estimate the total cost of care. They did so by making a set of assumptions about the number of hours of care that would be required in each of their four categories. They also chose to value care, both formal and informal, at £7 per hour; this figure being derived from information as to local authority hourly costs for basic formal care. On a basis of these assumptions, the working party calculated that the total value of long-term care required in 1991 was £42 billion, which could increase to £62 billion by 2031.

104. In order to check the reasonableness of these calculations, the working party estimated on an alternative basis the total value of long-term care provided in 1991 — including, as before, a notional element for the 'cost' of informal care. They used Laing & Buisson estimates of the cost of institutional care as £7 billion, and of professional homecare as £3.1 billion, then estimated themselves the number of hours of informal care provided, and assumed as before that this cost £7 an hour, giving a total cost for informal care of £33.9 billion and a total for all care of £44 billion.

105. Both sets of calculations made by the working party rest heavily on the assumptions made as to the value and future extent of informal care. Mr Brian Bussell of the Institute told us that they used the £7 per hour rate so that "we could relate the non-financial cost of informal care to the cost of formal care as well so that we could see the effect if some of the burden shifted from the informal carers to formal care."[170] The working party's

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[165] Ev. p264.

[166] *Financing Long-Term Care in Great Britain*, Institute and Faculty of Actuaries, 1993.

[167] Ibid, Table 4, page 17.

[168] Q125.

[169] Q129.

[170] Q136.

calculations are useful in that they draw attention to the potential effects of any reduction in the availability of informal carers to meet long-term care needs. At the same time, the lack of firm basis for the assumptions made as to the future costs and extent of informal care means that the estimate of the overall future financial cost of long-term care to the nation, like all such estimates, contains a very considerable element of guesswork.

(ii) Help the Aged

106. During the first phase of our inquiry Help the Aged submitted an estimate of the future costs of long-term care through to 2021. The estimate was founded on statistics showing that in 1991 meeting the hospital and community health, family health and personal social services needs of the over-75s cost an average of £2,100 per person, and that meeting the needs of those aged 65-74 cost an average of £900. These figures were then applied to population projections. Help the Aged concluded that costs might rise from £13 billion in 1991 to £17 billion in 2021. Such a simple projection ignores inflation and assumes that the pattern of costs, and of need within each age group, remains constant.[171] This projection does not include the costs of long-term care paid for by individuals, nor does it place any value on informal care provision.

(iii) Mr William Laing

107. A further estimate of likely future costs was provided by Mr William Laing of Laing & Buisson in his book *Financing Long-Term Care — The Crucial Debate*.[172] Mr Laing's calculations, which were based on the Government Actuary's principal population projection and assume constant age-specific usage of long-term care services (that is, that elderly people of a particular age in the future will use the same amount of services as their equivalents today) indicated that the proportion of GDP spent on the long-term care of the elderly would have to rise from 1.5% in 1992 to 3.5% by the time demand peaks in 2051. Mr Laing also estimated that in 1992 the State funded 70% of the costs of formal long-term care services (equivalent to 1% of GDP), and that if the State continued to meet the same proportion of the total care costs (i.e. 70%) this would rise to 2.5% of GDP by 2051. Mr Laing's estimate, like that of the Institute and Faculty of Actuaries working party, was based on a valuation of informal care at £7 per hour, which may be too high and is certainly not a figure on which reliance can be placed; the caveat we expressed in paragraph 105 above about the working party's overall estimate therefore applies also to Mr Laing's.

(iv) London Economics

108. In early 1996, the Institute for Public Policy Research published the results of a study commissioned from the consultants London Economics which included as one of its three key questions the issue of how much long-term care was likely to cost in the future.[173] This work built upon the Institute and Faculty of Actuaries working party's projections of the number of people likely to be needing long-term care in the future (see paragraphs 101 to 105 above). It used a different method of estimating costs, by modelling the future supply of informal care using carer characteristics derived from the 1990 General Household Survey. The authors concluded that the formal costs of long-term care (that is, the cost of the residential and domiciliary care sectors) would increase from £12 billion (1.8% of GDP) in 1995 to £33.5 billion (5.0% of GDP) in 2031. By modelling the income and wealth of pensioners they also provided an estimate as to how much of this cost will be borne by the taxpayer, allowing for the 1995 Budget changes. This proportion, they claimed, would increase from £8.8 billion (1.3% of GDP) in 1995 to £13.1 billion (2.0% of GDP) in 2031. This is a much smaller proportional increase than that in total formal care costs.

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[171] HC 19-III, Ev. pp66-67.

[172] Published by Age Concern England, 1993.

[173] *Paying for Long-Term Care*, 1996.

109. The authors provided estimates for the future costs of the informal sector. They argued that these will decrease from £38.8 billion in 1995 to £31.7 billion in 2031. Their model also estimated the opportunity cost to society of informal care, i.e. the value of these resources in their most productive alternative use. These opportunity costs included estimates of the cost of carers' time, the cost of goods associated with care provision, career costs and accommodation. The authors estimated that the opportunity cost to society of informal care will rise from £29.7 billion in 1995 to £53.7 billion in 2031.

(v) Dr David Whynes, University of Nottingham

110. A recent publication by the Association of British Insurers included an overview of the present state of long-term care in Britain by David K Whynes, Reader in Health Economics at the University of Nottingham.[174] This estimate took as its starting point Mr Laing's estimate of the total 1992 cost of long-term care as £42 billion. Current disability incidence rates (based on the 1986 OPCS disability study) were then applied to population projections, as well as assumptions concerning the resource usage for each category of disabilities. Dr Whynes estimated that the costs of long-term care for the elderly might increase by between £28 and £32 billion in real terms by 2041. This estimate includes an imputation of the value of informal care, derived from the work of the Institute and Faculty of Actuaries on which we have commented in paragraphs 101 to 105 above.

(vi) Department of Health

111. The DoH provided us with their projections of the future public expenditure costs of long-term care, which had not previously been made public.[175] These are projections of net costs to the tax-payer arising from social services expenditure (all social services provided for adults are included) and from NHS hospital and community health services expenditure on long-term care (all community health services for adults, except family planning, together with inpatient, outpatient and day hospital care for adults in the geriatric, learning disability and mental illness specialties are included).[176] The DoH told us that current social services expenditure on long-term care is roughly £6 billion per annum, which represents about 1% of GDP, whilst about £8 billion (or 1.3% of GDP) is spent on long-term care by hospital and community health services. These figures, and hence the DoH's projections founded upon them, do not make allowance for the costs of those people who pay in full for their care, or for the imputed cost of care provided free by friends or relatives.

112. The DoH made a range of projections based on different assumptions about changes in dependency levels, the extent of any increases in the real costs of long-term care, the extent to which there will be decreasing numbers of carers, and the extent to which there will be an increase in the number of elderly people able to afford their own care. There is wide variation in the results of the projections. The forecast for expenditure on long-term care in 2030 under the most optimistic assumptions for each variable is £12.9 billion at 1995-96 prices (0.9% of GDP), which is actually *less* than is currently spent.[177] Taking the most pessimistic assumptions for each variable, however, the forecast expenditure in 2030 is over five times greater, at £65.4 billion (4.8% of GDP).[178] The DoH comment that these two outcomes are in practice the *least* likely.[179]

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[174] *Long-Term Care for the Elderly*, David K Whynes in *Risk, Insurance and Welfare*, The Association of British Insurers, 1995.

[175] Ev. pp264-270.

[176] Ev. pp268-270.

[177] Ibid, Tables 3b and 6b.

[178] Ibid, Tables 3a and 6a.

[179] Ev. p264.

113. **The overall conclusion drawn by the DoH is that "on almost every scenario ... the absolute demand for long-term care is likely to rise steadily over the period, as is the real cost".[180] This will *not*, however, in the view of the DoH, necessarily lead to long-term care becoming unaffordable:**

> "it is noticeable that to take what some might regard as a very plausible set of assumptions — no significant change in dependency levels, a 1% per annum increase in real costs, a reduction of 10% over the period in the numbers of carers and a 1% per annum increase in the numbers of elderly people able to fund their own care — then the increase in the social services cost is no greater, and the increase in the hospital and community health services cost only a little greater, than the projected increase in GDP."[181]

Under these "plausible" assumptions the forecast expenditure in 2030 is £28.1 billion at 1995-96 prices (2.0% of GDP).

114. The DoH concluded that "the analysis does not suggest on most reasonable assumptions that we face an impending crisis of affordability in relation to long-term care costs". They also told us that **although the projections spanned a wide range of possibilities, almost all of the outcomes imply future rates of increase which are lower than those accommodated over the past 15 years.** It is nonetheless important to bear in mind that, like the Help the Aged calculations, these are only projections of the cost to the taxpayer, and not to the economy as a whole.

115. The DoH subsequently told us that they had commissioned the Personal Social Services Research Unit at the London School of Economics and Political Science to develop a model with the capacity to make detailed projections of long-term care demand and finance, which would inform policy planning and review.[182]

Projections of the Future Costs of Long-Term Care: Conclusions

116. What conclusions can be drawn from the variety of projections, each prepared on a differing basis and with differing assumptions, that we have outlined in this Section? While most of them indicate that the demand for long-term care is expected to increase in the future, **they do not support claims that we face a 'demographic timebomb', or at least not one that is likely to explode over the next two to three decades.** The demographic trends, which we discussed in Section III above, indicate that there will be significant increases in the numbers of elderly people and in the proportion of the population that they constitute. What remains uncertain is the extent to which these increasing numbers of elderly people will need long-term care, the extent to which informal carers will continue to provide the bulk of that care, and the impact that new medical technologies and treatments might have, both in terms of successfully treating what are currently chronic conditions and in terms of allowing more people to reach old age through more effective treatments of acute conditions earlier in life.

117. **We are concerned at the lack of good information on likely changes in the health status of elderly people, and we feel that there is also scope for more research as to what impact improvements in preventative and rehabilitation services could have in alleviating some of the additional demand for long-term care that will inevitably occur as the population ages. We recommend that the DoH commission research on both these areas.**

118. Many of our witnesses accepted that there is no imminent crisis of unaffordable care. The former Parliamentary Under-Secretary, Mr Bowis, commented that "there is not this great timebomb about to explode".[183] Mr Mervyn Kohler of Help the Aged told us that he thought we have "a manageable situation.... it still requires action, but it is manageable".[184]

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[180] Ibid.
[181] Ibid.
[182] Ev. p397.
[183] Q793.
[184] Q293.

Mr Brian Bussell of the Institute and Faculty of Actuaries agreed that their projected increases were of a similar scale in the future as they have been in the past.[185] Mr Paul Smee of the ABI said that "to pretend there is a crisis is not conducive to thinking through sensible solutions", although he qualified this by saying that "there is a difference between on the one hand being alarmist and on the other hand totally ignoring the issue and I think for a long time people have ignored the issue".[186]

119. It is clear from the evidence presented to us that there is highly unlikely to be a dramatic surge in the numbers of elderly people needing long-term care in the period up till 2020. The DoH's central projections indicate that the costs to the taxpayer of providing long-term care services are affordable up until 2031 (the furthest point to which DoH projections have been taken). As we have pointed out, many unofficial estimates showing spiralling future costs rest on estimates of the 'costs' of informal care which are unverifiable, probably inflated, and in any case only relevant in relation to that element of care, of unknown extent, which is now provided informally but in future may have to be provided formally.

120. However, the demographic trends in the middle decades of the next century indicate that there may be significant increases in costs in that period. Possible options for minimising these costs include improvements in preventative and rehabilitation services, although as we have already pointed out there is a lack of hard evidence about the cost-effectiveness of such approaches. We do have an extended window of opportunity within which plans for dealing with this eventuality can be drawn up.

121. The question which remains to be addressed is whether it is necessary in the comparatively short term, let us say during the period of the next Parliament or its successor, to undertake radical changes to the present system of financing long-term care. We received much evidence from those urging such changes, in a variety of forms, and we summarise and comment on these proposals in the pages that follow. A general point about our adopted approach should be made at the outset. Although we deal at some length with the pros and cons of alternative funding options, we are very much aware that a major option in its own right is to maintain the status quo, and continue with the current system whereby general taxation is used to provide NHS care free at the point of delivery and social care subject to a means test. In order fairly to represent the evidence submitted to us we will discuss in detail the various alternative funding options, but this should not be taken as indicating an assumption on our part that the status quo must be unsustainable and that the only argument is about what should replace it. No such assumption has been made.

V — DESIRABLE FEATURES OF ANY FUTURE CHANGES

122. In this section of our Report we set out a series of principles which we believe should underpin any changes that may be contemplated to the current arrangements for providing and funding long-term care services.

123. A number of our witnesses made suggestions as to what should be desirable features of any future system for funding long-term care. The ADSS, for instance, told us that any new system should "pass the tests of equity, quality, choice, affordability, security and transparency if it [is] to gain public acceptance and restore public confidence."[187] Anchor Housing likewise suggested that any future system should:

"• encourage and support independence;

• be flexible and able to cope with a person's changing (and multiple) needs;

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[185] Q145.
[186] Q23.
[187] Ev. p132.

- optimise the use of scarce resources (not just finance but skilled people);
- give people more control over their own situation; [and]
- be easily accessible by users and carers and provide support on an equitable basis".[188]

124. **We believe that any changes to present models of care and methods of financing long-term care should conform to the following key principles.**

125. **Principle 1: any changes should maximise independence, self-respect and choice for the individual.** At the heart of any system should be the encouragement of independence and autonomy for the individual and provision of a reasonable degree of opportunity for people to choose the type, and setting, of the long-term care that they require. It is also important that the system should be sensitive to the particular needs of ethnic and religious minorities.[189]

126. **Principle 2: any changes should be understandable and perceived as equitable.** We have already discussed the widely held public perception that the current arrangements for funding long-term care lack fairness.

127. **Principle 3: any changes should improve the way in which long-term care is planned, organised and purchased by multidisciplinary knowledged-based agencies.** The community care reforms are based on the aspiration, which we strongly support, that services should be purchased and provided based on the needs of the individual rather than on the interests of the service providers. Good information is therefore required on the needs of both individuals and local populations and on the effectiveness of the varying forms of long-term care services, including for example, preventative and rehabilitative services.

128. **Principle 4: Any changes should provide better support and encouragement to informal carers both in terms of practical help (e.g. training, respite care) or financial help.** Informal care remains, and will remain for the foreseeable future, the bedrock upon which long-term care provision is founded. Given the potential for changing demographic and other social trends to reduce the supply of informal carers, there is a strong argument for ensuring that priority be given to changes which will improve the ability and willingness of informal carers to provide care.

129. **Principle 5: Any changes should include mechanisms to ensure that an efficient and high quality service is provided in all care settings.** Long-term care services are often provided to a client group that is, by the nature of their conditions, a vulnerable group. It is clearly of some importance therefore, that mechanisms are in place to ensure that high quality services are provided in all care settings. There should be effective registration and inspection procedures and quality development programmes for both residential and domiciliary care services.

130. **Principle 6: Any changes should be affordable.** Public support for changes is only likely to be forthcoming if they are seen as being affordable by individuals as well as by the State. If there *were* to be movement towards a system of long-term care that is 'funded' as opposed to 'pay-as-you-go', then there should be a recognition that one generation would be expected to contribute twice, for its own future care as well as for the care needs of today's elderly people. Any such change would need to be phased in over a long period in order to be affordable and acceptable to the 'transitional generation' (for which see paragraph 193 below).

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[188] Ev. p196.

[189] For this see Q665; Ev. p197.

131. **Principle 7: Any new programme of public expenditure on long-term care should, in the case of services provided or paid for by the NHS, as now be available equally to all citizens according to their assessed need for care; and, in the case of means-tested social care services, be designed to meet necessary care need for citizens who have insufficient income or capital to pay for such care from their own resources.**

VI — OPTIONS FOR FINANCING LONG-TERM CARE

What should the State be responsible for providing?

132. In considering the future funding of long-term care, the first and in some ways the most fundamental issue to be decided is that of the extent to which the State should be responsible for providing that funding. We received a number of suggestions as to which elements it was right for the State to provide for. At one end of the spectrum the Greater London Pensioners' Association argued that the State should provide institutional and domiciliary long-term care services free at the point of use.[190] This would represent a major shift from the position which has obtained since the foundation of the NHS, whereby residential care is provided by the State on a means-tested basis, and would require significant amounts of additional resources to be provided to local authorities by central government to cover the lost income local authorities raise from charging for social care services. The DoH told us that in 1993-94 local authorities raised £414 million from charges for residential care and £145 million from domiciliary care charges.[191] In defence of the current system it could be argued that it protects those people in society who do not have the income, or who have insufficient assets, to meet the costs of their care, whilst ensuring that others are not receiving state help towards costs that they can clearly meet themselves. However, it is necessary also to recognise that the boundaries between free NHS care and means-tested social care have shifted since 1948, and that this shift has accelerated since the early 1980s, particularly with regard to nursing home care.

133. In our earlier report we pointed out the likelihood that many people currently receiving care in nursing homes on a means-tested basis would in previous decades have received care without charge in NHS hospitals.[192] We recognise that this client group might reasonably have expected that the NHS would pay for such care. A number of witnesses highlighted the apparent contradiction whereby nursing care is available for all ages and in all settings free on the NHS, *except* for those people receiving care in nursing homes.[193] The Royal College of Nursing (RCN) argued that the nursing element of long-term care should become the responsibility of the NHS.[194] Mrs Evelyn McEwen of Age Concern told us that "it is very difficult to argue that in the residential home setting or particularly the nursing home, that people should not receive that nursing slice of their care free."[195] Ms Christine Hancock of the RCN did, however, accept that such a change would not entirely solve the problems associated with funding of long-term care.[196] It would not necessarily reduce tensions between health and local authorities over who should be responsible for providing care: the argument might shift from where to draw the boundary between 'health' care and social care, to where to draw the boundary between nursing and non-nursing care, and also about the standard of nursing-home care to be paid for.

134. The RCN offered a "crude figure" of £250 million as the estimated cost of such a change (this being the difference between the average cost of a residential home care place and a nursing home care place, multiplied by the number of nursing home places).[197] We subsequently asked the DoH to provide its own estimate of the costs of the proposal. This

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[190] Ev. p348.
[191] Ev. p261.
[192] HC 19-I, para 18.
[193] Ev. p126; Q324.
[194] Ev. p126.
[195] Q324.
[196] Q475.
[197] Q474.

was less than the RCN's costing, at around £215 million a year at 1996/97 prices. Both this figure and that from the RCN relate to Great Britain as a whole (England, Scotland and Wales). The equivalent DoH figure for England alone is £180 million. The DoH gave us a detailed explanation of how these figures were arrived at, which we print in the Minutes of Evidence.[198] In summary, the bulk of the extra cost to the State is estimated to come from those in nursing homes who are currently self-funding (some 47,000 people in Great Britain). The cost of nursing input into nursing-home care is assumed to be the difference between the average nursing-home and residential care home gross fee — approximately £100 per week. This gives a figure for Great Britain of about £245 million. The DoH then added about £45 million to take account of some lost charge revenue and of likely behavioural effects (i.e. self-funders who would otherwise have chosen a residential home but who might now choose a nursing home at little or no extra cost to them). From this a further sum of about £75 million was deducted to allow for the saving to the DSS in non-means-tested benefits available to those who are self-funding but not to residents receiving state support. This gives the estimated net costs of £215 million for Great Britain and £180 million for England. The DoH add that as "there are a considerable number of uncertainties, ... the figures should be treated as a rough guide only".[199]

135. An alternative to this proposal would be to make *all* the costs of nursing home care the responsibility of the NHS, but we acknowledge that this may not be possible in current circumstances. However, **we do recommend that the concept of NHS nursing homes (or NHS-provided places) should be maintained and they should be provided when possible.** This would be more expensive for the taxpayer, as accommodation costs (sometimes called 'hotel' costs) would not be subject to a means test. It would also lead to similar arguments arising about whether a patient needed nursing care or residential care. The DoH's estimate of the costs of this proposal is around £670 million a year (1996/97 estimate, England only).[200]

136. Another, more radical, suggestion was put forward by Mr William Laing of Laing & Buisson. He considered that there might be merit in making all social and nursing care received in a residential or nursing home available on a non-means-tested basis, with means-testing being retained for 'hotel' costs.[201] He recognised that such a rule would also need to apply to long-term NHS care where currently all elements are free.[202] Such a scheme would not be without controversy as it would breach the fundamental principle of the NHS that all the costs of care, including hotel costs, are met by the State. It would also be likely to cost more.

137. Each of the proposals put forward by the RCN and by Mr Laing and discussed above has its advantages and disadvantages. Each could be argued to introduce more equity into the current arrangements and thus to represent an advance on the status quo; each, however, would lead to significantly increased public expenditure. The proposal by the RCN that the nursing element of long-term care should be the responsibility of the NHS, and therefore free at the point of delivery, while the accommodation costs of nursing home stays would continue to be means-tested, has the advantage that it clarifies what the State will pay for, eliminates perverse inventives for people needing nursing care to stay in hospital, and by comparison with the other options is relatively affordable, with the Government itself costing it at about £180 million per year.[203] The main disadvantage, other than the fact that it would cost more than the status quo, is that it would raise problems as to the definition of 'nursing care'. The proposal that *all* the costs of nursing-home care, including those of accommodation, should be the responsibility of the NHS, has similar merits and demerits, but is less appealing because its costs would be so much greater: more than three times as great, on the Government's figures. Finally, Mr Laing's proposal that all nursing *and* social care should

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[198] Ev. p401.
[199] Ev. p395.
[200] Q239,245.
[201] Q239, 245.
[202] Q173.
[203] Ev. pp395, 400.

be free, but all accommodation, including that in hospitals, should be means-tested, has the benefit of allowing for a seamless transition between different forms of care, but the great disadvantage of jettisoning the fundamental Health Service principle that all the costs of hospital care, including 'hotel' costs, are met by the State.

138. **Of these various proposals, we believe that the RCN suggestion that the nursing costs of long-term care should be the responsibility of the NHS is the most immediately attractive in terms of equity. It has the merit that it would tackle the most manifest unfairness of the present system, the way 'health care' is currently defined to exclude 'nursing care in nursing homes'. Many members of the public quite understandably find this definition baffling. It is clearly illogical and indefensible that whereas someone who is ill in a hospital acute ward receives free nursing care, another person with similar medical problems who is cared for in a nursing home is means-tested for their nursing care. As the RCN point out, this means that "the physical location, rather than the individual's needs, determines whether or not the NHS pays for care".[204] Given that the majority of people in nursing homes are elderly, the effect of the present system is to discriminate on grounds of age. However, the costing of this option is problematic. In putting forward its estimate that implementing the option in England would cost the taxpayer an extra £180 million per annum, the Government emphasises that this calculation is "based on current patterns of care and make[s] no allowance for possible increases in take-up of places nor any effect of increases in fees if there is a large demand effect".[205] We recommend further early examination of, and consultation on, this proposal.**

139. **One difficulty in assessing the relative merits of the options which have been canvassed before us is that it is not yet possible to compare their estimated costs to the public purse with those of partnership schemes, the Government's own preferred option for tackling the problems of long-term care funding. We asked the Government to supply us with their current best estimate of the cost of the various partnership options proposed in their discussion document, but received a reply that "it would not be meaningful to produce an estimate until the points made in responses to the consultation paper have been studied and details of the scheme have been settled".[206] Later in this report we express our concern that the Government has issued a discussion paper on partnership schemes without producing a range of estimates of the public expenditure implications of this policy option.**

Assuming that there is an element which the State should not pay for, should the Government give any encouragement or incentives to people to make provision to pay for some or all of their care?

140. During the course of the inquiry we received a wide range of ideas as to how people might be able to contribute towards the cost of their own long-term care. In these paragraphs we discuss the consequences of these options. We start by stressing that, even if it were decided in principle to go down this road, no one solution would be suitable for all people. Pensioners are not a homogeneous group. As with the general population, their income and wealth vary substantially.[207] Elderly people typically derive their incomes from one or more of the following sources: state pensions, income support, occupational pensions, earnings, savings, investments and other capital assets. Even elderly people who are asset rich tend to be income poor. Table 6, which is based on the 1994/1995 Family Expenditure Survey, shows the percentage of retired single person households in given gross weekly income bands.

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[204] Ev. p127.

[205] Ev. p395.

[206] Ev. p395.

[207] Much of the material in this section on the income and wealth of pensioners is drawn from Dulcie Groves, *Costing a fortune? Pensioners' financial resources in the context of community care*, which provides a good overview of research into this subject. This is published in Allen & Perkins, *op. cit.*

Table 6: Percentage of all households and of retired single person households in given gross weekly income bands, UK 1994/95

All Households decile group	£ per week	Percentage of retired single persons in each decile group
lowest decile (10%)	less than £77 per week	38
second	£77-116 per week	30
third	£117-161 per week	16
fourth	£162-222 per week	6
fifth	£223-290 per week	5
sixth	£291-366 per week	2
seventh	£367-454 per week	2
eighth	£455-555 per week	1
ninth	£556-727 per week	0
highest decile	more than £727 per week	0

Source: Laing & Buisson, Care of Elderly People Market Survey 1996 — Ninth Edition, p 118.

This table illustrates that two-thirds of retired single-person households have an income of less than £116 a week. Five out of six such households have an income of less than £161 a week.

141. In 1993, 15% of pensioners (1,599,000 people) in the UK had such low levels of income that they were successfully claiming income support.[208] There are also over a million local authority/private tenant retired households not drawing income support, but sufficiently poor to qualify for means-tested housing benefit.[209]

142. Estimates from 1989 based on data from the Government Actuary's Department and the Family Expenditure Survey show that the percentage of pensioner couples with occupational schemes had risen by 8% since 1979 to 73%, with an average gross weekly pension of £62.70. There has also been a steady decline in the economic activity rates of people over pensionable age, to around 12% of men and 19% of women by 1988.[210]

143. Taking these statistics as a whole, a number of researchers have produced estimates of the numbers of pensioners who would be able to meet residential care fees from their own income. I. Gibbs estimated that only 4% of households aged 75 and over could do so. S. McKay found that only in the top quintile (20%) could elderly people able to pay for such care be found. These were likely to be younger pensioners whose income from pensions and savings was supplemented by continuing earnings (amounting on average to 13% of gross household income in this quintile).[211]

144. The extent to which pensioners have significant *capital* assets is, therefore, an important consideration in determining the extent to which elderly people might be able to contribute towards the cost of their own care. While many pensioners are income-poor,

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[208] *Official Report*, 8 July 1996, c57-58w; 2 May 1996, c629-30w.

[209] Dulcie Groves, *Costing a Fortune? Pensioners' Financial Resources in the Context of Community Care*, in Allen & Perkins, *op. cit.*

[210] Ibid.

[211] Ibid.

owner-occupation among the over 65s has risen from 44% in 1975 to 54% in 1991.[212] A much-quoted statistic is that from Professor Chris Hammett who has estimated that, under the arrangements in force before the 1995 Budget, between 32,000 and 40,000 of householders a year might need to sell their houses to pay for residential and nursing home places.[213] This statistic rests on the assumption that two-thirds of those who enter residential or nursing home will actually sell their home. This assumption itself is based on an analysis of differences between estimates of the number of elderly people with housing assets who die (house inheritance levels were estimated at between 128,000 and 133,000 in 1990) and Inland Revenue statistics on 'estates passing at death' (101,000 in 1989/90). In our view the estimate that between 32,000 and 40,000 householders a year may need to sell their homes is not based on any substantive evidence but on a series of assumptions which may well be incorrect. Although the problem of enforced sales *may* be widespread, it is simply not possible on currently available data accurately to quantify it.

Long-Term Care Insurance

145. One option for people who wish to avoid using their income or assets to fund their long-term care is for them to purchase a suitable insurance policy. The ABI told us that "long-term care insurance products offer individuals the chance of avoiding all or some of the future costs of long-term care, in their own home or elsewhere, by insuring the risk through a lump sum payment in advance, or regular premiums".[214] An alternative option, particularly for those about to enter a residential or nursing home, is to purchase an 'immediate benefit contract'. This is a form of annuity which pays out, either indefinitely or for a fixed period, an annual sum.[215] The take-up of long-term care products in the UK has not been great to date, with only around 10,000 policies being sold and a very limited claims experience. There is as yet only a limited range of such products, most of which were introduced comparatively recently.[216]

146. We think that there are a number of reasons as to why take-up of such policies has been so low. Firstly, as many witnesses told us, the majority of people have not hitherto placed financial planning for their long-term care needs at the top of their personal agenda, particularly during their working lives.[217] This would reflect the widespread expectation that the State would pay for their long-term care. The ABI stated that the typical age-range at time of purchase of these policies is 60 to 75.[218] Secondly, BUPA argued that people lack confidence in their ability to pay monthly premiums over very long periods.[219] Thirdly, long-term care insurance is not cheap. Mr Brian Wood of PPP Lifetime Care plc told us that for a 65-year-old man taking out a policy that would pay out £10,000 per annum (an average sum insured), the premium would consist either of monthly payments of £60, or a single payment of £7,340.[220] Cover for a woman of the same age would cost more, owing to the longer life-expectancy of women. The National Association of Pension Funds (NAPF), who represent employers providing occupational pension schemes, supplied us with tables showing a typical range of single premiums currently available for long-term care products, and corresponding monthly premiums:—

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[212] *Inheritance in Britain: the boom that never happened*, PPP Lifetime, 1995.

[213] Ibid.

[214] Ev. p14.

[215] Ev. p41. In the Government's consultation paper these are referred to as Immediate Needs Annuities (see paragraph 173 below).

[216] Ev. p15.

[217] See, for example, Ev. pp2, 14.

[218] Ev. p14.

[219] Ev. p341.

[220] Q5.

Table 7: Single Premiums for Long-Term Care Benefits of £1,600 Per Month (£19,200 Per Annum)[221]

Age	Male	Female	Couple
60	£17-21,000	£28-38,000	£46-53,000
65	£18-21,000	£30-39,000	£47-54,000

Source: Ev. p181.

Table 8: Monthly Premiums for Long-Term Care Benefits of £1,600 Per Month (£19,200 Per Annum)

Age	Male	Female	Couple
60	£114-120	£138-169	£247-260
65	£143-144	£173-211	£314-319

Source: Ev. p181.

The difference between the premiums cited by PPP and those by the NAPF is largely attributable to the fact that the latter would secure total cover for nursing-home care of £19,200 a year — somewhat on the high side, as the Laing & Buisson average for such care is £18,000 a year — whereas the PPP level of cover, £10,000 a year, assumes that the policy-holder has extra sources of income to top up his or her insurance benefits. Mr Wood of PPP told us that "we are not attempting to fund for the full costs of long-term care because everybody will have a residual element of income that they will be able to apply to care when they move out of their own home into a nursing home".[222]

147. The NAPF argued that long-term care insurance was very expensive because of two main factors: firstly, the market was relatively new and underdeveloped and there was little competition; and, secondly, insurance providers were constrained by the lack of sufficient UK data about the average length of time for which long-term care services are required, coupled with the lack of claims experience and the risk that the very availability of long-term care insurance might change people's behaviour patterns so that they chose to enter care earlier.[223]

148. Whether the cost of care is met by insurance or by taxation, the principle is that of pooling the risk of an individual needing long-term care over a large population. It is a cause for concern that there would be a temptation for insurance companies to exclude some categories of people from buying insurance, such as those with certain genetic conditions. However, we were told by Mr Jerry Barnfield of the Association of British Insurers that

> "most of the insurers in the long-term care market do not exclude pre-existing conditions. What we do to some extent is underwrite people by either sending a nurse round or getting reports from doctors, et cetera, just to make sure that they are... reasonably healthy, so that we do not necessarily take on people who can claim immediately or almost immediately. We do not think it is right, if you are insuring for a long-term risk, that you can exclude conditions where it may be difficult to judge in 20 years' time whether there was an existing condition at the time of the sale."[224]

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[221] Ev. p181.

[222] Q3; see also Q7-9.

[223] Ev. pp181-82.

[224] Q38.

149. Long-term care insurance is a complex financial product which is sometimes sold to what many people might consider to be a vulnerable and financially unsophisticated group, particularly those people purchasing an annuity on their entry into long-term care. Notwithstanding this, long-term care insurance is not a product regulated by the Financial Services Act (FSA) 1986.[225] The ABI have introduced a Statement of Best Practice covering product design, sales and marketing standards which companies are expected to comply with on a voluntary basis.[226] Mr Brian Wood of PPP Lifetime Care plc told us that while they supported the development of the ABI code, they believed it had a fatal flaw in that it was not enforceable.[227] PPP Lifetime Care plc argued that bringing the sale of long-term care insurance within the scope of the Financial Services Act would:—

"• ensure that only 'fit and proper' individuals, who have been fully trained and are continuously monitored, are able to advise on and sell long-term care;

- ensure that a full analysis of the customers' needs is conducted before a product is recommended;

- ensure that provision for long-term care is properly considered as part of any financial advice process; and

- limit the sale of inappropriate 'limited claim' products".[228]

Mrs Evelyn McEwen of Age Concern supported this call,[229] as did BAT UK Financial Services.[230]

150. The Government's recent consultation paper also considers this subject. It concludes that "the Government believes that in general the FSA should not cover indemnity insurance products."[231] However it accepts that there is a case for making long-term care insurance products an exception to the general rule, and seeks the views of the public and interested parties on whether this should be done.[232]

151. **The present low uptake of long-term care insurance makes it difficult to judge its potential for future expansion. Such insurance is at present too expensive for more than a small minority of the population to contemplate: PPP Lifetime Care plc described their client profile as people belonging to socio-economic groups AB, frequently retired from professional or vocational occupations, usually owning their home outright and often possessing an asset base of around £250,000.[233] Witnesses from the ABI told us that this probably represents the upper end of the market, and that some companies offered less ambitious but more affordable policies;[234] nonetheless, the fact remains that such policies are out of reach of the pockets of most people. Even an expansion of the number of policy-holders will not in itself lead to lower premiums.**

152. **We believe that it is essential that the long-term care insurance market is subject to formal regulation, either through the Financial Services Act 1986 or by some other means. This may cause problems of definition, in that it will be necessary to define long-term care insurance so as to distinguish it from medical insurance, but we consider that such problems can be overcome. The need for regulation rests partly on the sheer size of financial commitment for the individual arising from this form of insurance. We also**

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[225] Ev. p8.
[226] Ev. p15.
[227] Q87.
[228] Ev. p8.
[229] Q314.
[230] Ev. p84.
[231] *A new partnership for care in old age*, Cm 3242, paragraph 9.35.
[232] Ibid., paras 9.38-40.
[233] Ev. pp3-4.
[234] Q51-53.

note the views of witnesses from the insurance industry itself, who consider that long-term care insurance will not 'take off' commercially until the public is reassured that they are protected against the kind of unscrupulous practices which took place some years ago in respect of the selling of personal pension plans. We were told that there is, ominously, "already evidence that the sale of long-term care is attracting individuals and companies who see the lack of regulation as attractive".[235] For these reasons we strongly recommend that the Government takes the necessary steps to set up an *enforceable* system of regulation to ensure that individuals are protected against unscrupulous practice and that they can be reassured that insurance packages offered will be appropriate to their needs and financial circumstances.

Partnership Schemes

153. We received a number of submissions arguing that one way to improve the attractiveness of long-term care insurance policies would be to introduce so-called 'partnership schemes'.[236] The Government itself has recently stated that it favours the introduction of such schemes in the UK, and following a consultation exercise is expected shortly to announce further details of its proposals.[237] Partnership schemes give some additional protection of assets against the means test when it is applied. There are two main types, those that disregard all an individual's assets once he or she has funded his or her own care with the help of insurance for a pre-defined period, e.g. two or three years (*total asset protection schemes*) and those that increase the capital asset threshold for every pound of insurance benefit payable (*'£ for £' schemes*).[238]

154. Partnership schemes have been introduced in a number of US states. Four schemes currently exist: in Connecticut (established in 1992), Indiana (1993), New York (1993) and California (1995). The Government's recent consultation paper recognises that take-up of partnership policies has been lower than expected where they have been introduced (only 2,327 so far sold in Connecticut, against a target of 50,000 for the first five years of the scheme; and 9,800 in New York), but argues that this because of the high standards required of the policies.[239] Partnership policies in the US tend to be more expensive than non-partnership policies since they must include indexed benefits to gain the approval of the State authorities; non-partnership policies tend to have fixed benefits and so are cheaper.[240] The introduction of partnership arrangements has apparently had a spin-off effect in terms of increasing awareness and sales of other, less expensive, forms of long-term care insurance; for instance, we have been told that in New York State in 1995 there was a 60% increase in new business over 1994, but we received no evidence as to the actual volume of increase.[241]

155. Each of the four US schemes offers protection against means-testing by Medicaid, the joint federal/state programme which provides nursing-home, residential and other care services. The scheme adopted in New York gives total asset protection once someone has used insurance to pay for their care for three years. In other words, however wealthy an individual is, he or she will receive publicly paid-for care after three years of insurance. The scheme is designed to appeal to those with very high assets but relatively low income, and to attempt to discourage such people from divesting themselves of their assets (we have been told that in New York City alone there are 3,000 tax lawyers advising people on asset deprivation).[242] This scheme is therefore tailored for the specific circumstances of New York, and has features which render it an unsuitable model for adoption in the UK: in particular, it would be likely to be too costly for the taxpayer since it means that those people

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[235] Ev. p8.

[236] See, for example, Ev. pp13-14, 18, and 184.

[237] This was originally announced in the 1995 Budget Statement (*Official Report*, 28 November 1995, cc1067-1068). A consultation paper was published in May 1996: *A New Partnership for Care in Old Age*, Cm 3242.

[238] Cm 3242, Annex D.

[239] Ibid.

[242] Ibid.

[243] Q69.

who can afford to purchase an insurance policy to pay for all of their future care may decide to purchase a limited benefit period policy and hence rely on the State once insurance benefits cease.

156. In the other three US states the schemes operate on a 'dollar for dollar' basis; that is, the capital assets disregarded by the means test are increased by $1 for every dollar of insurance benefit paid.

157. By capping the potential liability to the insurance company, partnership schemes reduce the risk to the insurance sector and allow them to reduce significantly the cost of their policies. Mr Brian Wood of PPP Lifetime Care plc told us that a scheme which only paid benefits for two years, after which the State would take over responsibility, could reduce premiums by up to 40%.[243] This would be a greater reduction in the level of premiums than appears to be likely under the Government's preferred options — but of course this would also entail greater costs to be borne by the taxpayer.

158. Whether a partnership scheme costs the taxpayer more or not depends on the particular characteristics of the scheme. As a general principle, the longer that an individual is required to protect his or her assets, the lower the cost to the taxpayer because there is an higher chance that the individual will not survive past the period during which he or she is self-supporting.

159. The Government is contemplating the introduction of a partnership scheme in the UK which would be a form of '£ for £' scheme. Two options are identified in the recent consultation paper:—

- to disregard for the purpose of the means-test an extra £1.50 of capital for every £1 of insurance benefit taken into account; or

- to disregard for the purpose of the means-test an extra £1 of capital for every £1 of insurance benefit taken into account, plus an extra £15,000 of capital if the individual has funded his or her own residential care for four years.

160. The consultation paper concludes that the cost of the first option might be more than double than that of the second (presumably because of the long period during which an individual must fund his or her own care in the second option), and that each would advantageous for different groups of people. The consultation paper states that

> "The first option would be more attractive to people with more modest assets and incomes, who would not be able to afford to fund their care for four years and so to earn the extra £15,000 of protection available under the second option. The first option could also be more attractive to people with rather more assets but still modest incomes. People with higher incomes and higher assets, on the other hand, might find the second option more attractive, since they could meet most of their costs over the four years from income and would not need to take out so much insurance."[244]

The consulation paper does not define what is meant in this context by "modest" and "higher" incomes and assets. It does, however, include illustrative examples of the cost of a partnership scheme for two individuals.

161. The first example is that of a man aged 65 in the North of England with an income of £5,000, savings of £10,000 and a house worth £60,000.[245] To pay for lifetime insurance benefits of £12,500 a year for nursing home care (or £7,500 a year for residential care), the Government claim he would need to pay a single premium of £7,500 or a monthly premium of £75. (Given that the average annual cost of nursing-home care is £18,000 and of

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[243] Q69.

[244] Cm 3242, para 9.10.

[245] Cm 3242, paras 9.20-23.

residential care £12,700,[246] this example clearly presupposes that the man in question would be able to use a further part of his income to 'top up' his insurance benefits.) In order to protect his house from means-testing, and taking into account the standard means-test capital disregard, the man would need to buy a policy which would pay benefits up to £34,000 under the Government's first option (of a '£1.50 for £1' partnership scheme), or one which would pay benefits up to £50,000 under the Government's second option (of a scheme which gave '£1 for £1' protection plus an extra £15,000 protection after four years of self-funding in residential care). Under the first option, the man's policy could cost £5,000 by single premium or £50 a month, around a third less than the non-partnership cost; under the second option, his policy could cost £6,250 by single premium or £62.50 a month, around a sixth less than the non-partnership cost.

162. The Government's second example is that of a woman aged 65 in the South-East of England with an income of £10,000 and a house worth £80,000.[247] To pay for lifetime insurance benefits of £10,000 a year for nursing home care (or £7,000 a year for residential care), the Government claim she would need to pay a single premium of £9,000 or a monthly premium of £90. (As in the first example, it is clearly assumed that the woman would be able to use her income to top up her insurance benefits, which in themselves would fall significantly short of covering the full costs of care.) In order to protect her house from means-testing, and taking into account the standard means-test capital disregard, she would need to buy a policy which would pay benefits up to £47,000 under the Government's first option ('£1.50 for £1'), or one which would pay benefits up to £55,000 under the Government's second option ('£1 for £1' plus an extra £15,000 protection). Under the first option, the woman's policy could cost £6,750 by single premium or £67.50 a month; under the second, her policy could cost £7,200 by single premium or £72 a month.

163. In each of these illustrative examples, the individual concerned, though not wealthy, is better off than many elderly people who will need long-term care. It is difficult to imagine people on lower incomes than these being able to afford partnership insurance. The man's income of £5,000 per annum puts him almost in the top third of pensioners by income, and the woman's income of £10,000 almost in the top ten per cent.[248] It is the better-off elderly who are most likely to benefit from partnership insurance.

164. In order to arrive at a fuller picture of the impact partnership schemes might have, we asked the DoH to provide further examples of illustrative costs in the following scenarios:—

a) a man, aged 65, with an annual income of £7,000 and a house worth £80,000, living in the South-East of England, who wished to protect the entire value of the house, under both of the Government's options; and

b) a woman, aged 65, with an annual income of £3,500 and a house worth £40,000, living in the North of England, who wished to protect the entire value of the house, under both of the Government's options.

165. In response the DoH told us that

"it is not for the Government to say how much insurance under a partnership scheme might cost any particular individual: the insurance companies themselves will determine this. The examples in the consultation paper were intended to illustrate how the partnership scheme might work in practice, not to provide a definitive guide to costs. They used figures for costs provided earlier this year by industry contacts, but the consultation paper itself was intended to stimulate further thinking in the industry about the pricing of policies with a limited period of cover, so they should be taken only as a rough guide to possible costs."[249]

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[246] See paragraph 29 above.

[247] Cm 3242, paras 9.24-26.

[248] See Table 7 above.

[249] Ev. p395.

166. **It is difficult to regard this as a reasonable response to our request. We did not ask for "a definitive guide to costs", but for precisely the same kind of "examples ... intended to illustrate how the partnership scheme might work in practice" that the Government had already provided in detail in their consultation paper.**

167. In the absence of figures supplied by the Government, we asked one of our specialist advisers, Mr Peter Gatenby of PPP Lifetime Care plc, to provide us with his own estimates of illustrative costs under a wide range of scenarios. These are set out in the Minutes of Evidence.[250]

168. Mr Gatenby's examples indicate that partnership schemes would reduce the cost of long-term care insurance for many individuals, depending on their exact financial circumstances. Interestingly, however, his second example highlights the fact that partnership schemes may in some circumstances lead to individuals having to over-insure in order to safeguard their assets. In these circumstances it would be cheaper for the individual to take out normal long-term care insurance.

169. The consultation paper does not put an overall price on either partnership option. We are therefore unclear as to what will be the extra additional cost to the taxpayer of the proposed schemes. In a recent Written Answer, responding to a question as to the total public cost of introducing a partnership scheme in which the average value of insurance claimable is £30,000, the former Parliamentary Under-Secretary, Mr Bowis, stated that:

> "the cost of the scheme would depend on a number of factors, including the level of protection from means testing earned by indemnity insurance and immediate needs annuities, the number of people with partnership products who need residential care and their asset holdings."[251]

170. We received a similar answer in response to a request that the DoH provide us with their current best estimates of the cost to the taxpayer of the various partnership options proposed, including estimates of the likely take-up of the scheme, the numbers of people with partnership products who would need residential care, and those people's asset holdings. The DoH's response stated that

> "the cost of the partnership scheme to the taxpayer will depend on a number of factors, such as Government decisions on the details of the scheme (including the level of protection from means-testing to be given); how the market for insurance develops and the level of take-up achieved; and demographic factors, including the number of people who need long-term care in future and their asset holdings. Clearly, the Government will need to have an estimate of the range into which the costs of the scheme are likely to fall before proceeding with it, and we shall provide the Committee with this when it is available. However, it would not be meaningful to produce an estimate until the points made in responses to the consultation paper have been studied and details of the scheme have been settled. It is clear, however, that the costs of the scheme in the short term are likely to be relatively small, and that whatever scheme we decide on, it will take time for costs to build up."[252]

171. **Once again, we cannot regard this as a satisfactory response to our request. Given that eight months have now passed since the Chancellor of the Exchequer announced the Government's interest in partnership schemes, we would regard it as astonishing if the Treasury and the DoH have not worked out a likely range of costs under the different variables which may be applicable. Given also that the Government has stated its wish to consult on the options it proposes and to initiate a national debate, we see no reason why these rough estimates should not be made public. It is ironic that the Government *has* been prepared to give us its estimate of the cost of the RCN's proposal that the nursing-care element of long-term care should be an NHS**

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[250] Ev. p401.

[251] *Official Report*, 14 May 1996, c419w.

[252] Ev. p395.

responsibility, which is not Government policy,[253] but is not prepared to supply its provisional costings of a proposal which it has announced to Parliament as likely to be adopted.

Partnership Schemes: Conclusions

172. **In our view partnership schemes may be beneficial for some people: *how* beneficial, and *to whom*, will depend on a range of decisions to be taken by Government and by insurance companies. It is important to recognise that the primary purpose of partnership schemes is asset protection rather than long-term care insurance as such. For the foreseeable future many people will either be too poor to be able to afford such schemes, or too lacking in assets to need them. Equally there will be people whose assets are so substantial that to safeguard them by means of a partnership scheme would require over-insurance, a costly option just to get access to State-funded care at some stage in the future. We would be worried by any suggestion that partnership schemes are 'the answer' to the problems of long-term care funding. At best they may form a useful part of an overall package that may include other mechanisms such as equity release schemes, which we discuss later in this report. Experience of partnership schemes in the United States is at too early a stage for meaningful lessons to be drawn for the UK. The overall cost to the taxpayer will be a critical consideration, as only when this is known, or can reasonably be estimated, will it be possible to assess whether partnership schemes offer a greater degree of public benefit than some of the other proposals discussed in this report. We deprecate the Government's failure to provide even rough-and-ready costings of its various options. Until such costings are provided, the taxpayer is in effect being invited to sign a blank cheque.**

Immediate Need Annuities

173. For those people about to enter long-term care or who have a high risk of needing long-term care in the future (perhaps due to the onset of early dementia or other conditions) long-term care insurance, even under a partnership arrangement, may not be available or is likely to be prohibitively expensive.[254] The Government's consultation paper outlines another financial product which might be of benefit to such people: an 'immediate needs annuity.[255] This annuity pays out an annual benefit, either infinitely or for a fixed period, or until the death of the beneficiary if that is sooner. As in the case of long-term care insurance, it does not guarantee a financial return to the beneficiary.[256] The Government proposes to include such products within the partnership schemes, although with a low level of protection of assets. This is to avoid distorting the market in favour of immediate annuities which might result in higher costs to the taxpayer.

A Role for Pensions?

174. A number of our witnesses suggested that changes in the regulations governing pensions could also help people provide for more of their own long-term care.[257] The Prudential Assurance Company suggested that pensions offer the most practical way of enabling people to provide for future long-term care costs during their working lives.[258] Under their proposals, contributions would need to be increased from both the employee and employer; these would build up tax-free in the pension fund. At retirement individuals would need to decide how to provide for long-term care, the options being (a) using part of any lump-sum or (b) setting aside a portion of retirement income to pay for regular premiums.[259]

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[253] See para 134 above.

[254] Ev. p40; Q47-50.

[255] Cm 3242, Section V.

[256] Ibid.

[257] Ev. pp165-169, 184; Q201.

[258] Ev. p165.

[259] Ev. pp168-169.

175. An alternative approach suggested by some witnesses would be to allow pensioners to draw a reduced pension initially, which could be increased if long-term care was required later in retirement.[260] Cannon Lincoln launched such a pensions/long-term care product some four years ago, but the Inland Revenue subsequently ruled that this was an improper use of pensions and the product was withdrawn.[261] The Government is seeking further views on whether the regulations governing occupational pensions schemes should be changed to allow pensioners to opt to take a smaller initial pension in return for a larger pension later on.[262]

176. The drawback of using pensions to fund long-term care is that many people would need to invest significant extra amounts in their pensions (with a corresponding cost to the taxpayer through income tax relief) in order to ensure that they have a large income stream in retirement to pay for any long-term care they might require. Long-term care is, however, according to statistics cited by the Government, only likely to be required by one in six who reach retirement age.[263] Mr Brian Arrighi of Prudential Assurance Company Ltd accepted therefore that people would generally have to pay four or five times as much for a savings vehicle (i.e. pensions) as they would if purchasing equivalent insurance.[264]

177. The NAPF supplied us with copies of recent research they had conducted into the viability of providing long-term care benefits from current occupational schemes. They concluded that "deferring pension schemes in order to pay for long-term care is not a viable option at present for the majority of members of occupational pension schemes", and that purchasing a lump-sum from pensioners' actuarial reserves would leave the bottom 25% of male pensioners, and 50% of women pensioners, with no pension at all.[265] Other witnesses, however, argued that NAPF had overestimated the costs of long-term care services and insurance products, and thus undervalued the potential contribution of pensions.[266]

178. Some would argue that people should be encouraged to save more, where practicable, for their retirement. Such savings would of course lead to higher incomes in retirement which could be put towards the cost of any long-term care that is required. The Government's consultation paper argues that there are significant problems in extending the boundaries of pension schemes to include long-term care benefits, in particular the costs for both contributors and the taxpayer, the potential extra complexity of pension administration and the need to preserve the portability of pensions.[267] We received similar comments from Bacon & Woodrow, Consulting Actuaries, who argued that pensions and long-term care products should be kept as separate categories.[268]

179. **We acknowledge the weight of the arguments set out in previous paragraphs, and accept that pensions are not likely to prove a suitable vehicle for the funding of long-term care, and that the two categories of financial arrangement should be kept separate. This is not to say that a system whereby people pay contributions into a separate fund to cover their long-term care at the same time and in the same way as they make pension contributions might not have practical attractions, depending on what overall system for funding long-term care is chosen. The automatic and regular deduction of small amounts of income, as in taxation, is a relatively painless way of making financial provision, and might be particularly suitable as a means of providing long-term care cover for the younger generations, those under 50. In addition, it is, of course, possible under current arrangements for an individual to take a reduced pension, and a lump sum which could be used to purchase a dedicated long-term care insurance policy.**

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[260] Q250, 506, 547.

[261] Ev. pp12-13.

[262] Cm 3242, paras 11.16-11.22.

[263] See para 32 above.

[264] Q510.

[265] Ev. pp182-183.

[266] Ev. pp44-45.

[267] *A new partnership for care in old age*, Cm 3242, Section VII.

[268] Ev. p43.

180. **However, the specific suggestion that pensioners should be allowed to opt for a smaller initial pension in return for a larger pension later on, which would be used to fund the costs of long-term care, seems to us to be flawed.** A hypothetical example will show why. Let us assume that a man aged 65 was able to retire on a pension of £10,000 per annum. On current annuity rates this would mean that his retirement fund was £86,880. In order to be able to increase his pension to £17,000 per annum once he reached age 75, he would need to take a reduction in the initial pension and keep the remaining amount in the fund for a further ten years. Again using current annuity rates, and an assumption that the fund earns 8% per annum, the initial pension would need to be reduced to £5,830 in order for there to be a big enough fund at age 75 to increase the pension to £17,000. In ten years' time it is likely that the average annual cost of a nursing home will be well in excess of £17,000; if we experience inflation of about 5% per annum the cost will be about £27,000. **From these calculations it is clear that the variable pension option does not offer a convincing solution to the problem of fully funding long-term care costs, at any rate for other than a minority of rich people.**

Equity release schemes

181. A range of other options, some complementary to those discussed earlier, were suggested during the course of the inquiry. One was that elderly people should be enabled to draw more easily upon housing assets. At present, if they lack other, liquid, assets, many people who have considerable resources 'locked away' in property may not be able to afford the lump-sum payments for long-term care insurance. It could be argued, therefore, that there is a need for financial products that will allow them to release assets held in the form of housing.

182. Housing equity release schemes have had a justifiably poor image in the past, due to misselling of poorly designed products within the industry in the late 1980s. This led to crippling financial burdens being placed on some of the most vulnerable members of society. Many witnesses called for improved equity-release schemes to be available to allow people to convert housing equity into cash to pay premiums.[269] One such example was proposed by Edward Richards, Tim Wilson and Sean Lyons of London Economics, an economic consultancy firm.[270] They advocate the establishment of schemes in which individuals commit a part of their estate to cover the costs of any long-term care they might need (an arrangement they term 'Partial Equity Release Insurance'). In effect, this is a form of long-term care insurance but with the premium being paid in one go from their estate after the individual's death. Richards *et al.* argue that the key advantages of such a scheme would be that:—

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- an individual's house is retained to the end of their life; there is no need to sell up to fund care during life;
- the bulk of the value of inheritance is protected;
- the policy requires no new claim on disposable income;
- the policy focuses on those at or near retirement who are most likely to be receptive to the need to have cover for long-term care; and
- funding is consistent with the means available to those at or near retirement age."[271]

183. **In our view improved equity-release schemes may have a useful part to play in enabling asset-rich but income-poor people to make provision for their long-term care whilst also protecting a proportion of their assets. They would introduce a flexibility which is lacking in current arrangements. Such schemes would be attractive if they**

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[269] Q200.

[270] *Paying for long-term care*, The Institute for Public Policy Research, 1996.

[271] Ibid, Section 7.

allowed, for instance — to take an example we consider realistic — a couple owning an average-value house to purchase long-term care insurance with a three-year benefit period for about one-fifth of the value of the house. In other words, giving up one-fifth of the value of the house now would protect the remaining four-fifths if this happened in conjuction with a partnership scheme.

184. **However, in view of past experience, it is essential that such equity-release schemes should be properly regulated, as part of the wider system of regulation of long-term care insurance we recommend in paragraph 152 above. The regulation must ensure that schemes fulfil, as a minimum, the following criteria:**

- **the individual concerned should have an absolute right to remain in his or her home for as long as he or she wishes to;**
- **he or she should have an absolute right to move house, subject to the equity release provider not suffering financially, if this is what he or she wants to do;**
- **he or she should know in advance the maximum amount, in cash terms or percentage of house value, that the arrangement will cost him or her; and**
- **he or she should know in advance which, if any, factors may influence the amount involved, and their relative importance.**

Tax Relief

185. Another alternative approach by way of encouraging people to make provision for themselves would be to allow tax relief on the insurance premiums paid. Currently insurance premiums are paid into a gross fund which does not attract tax, and benefits from the policy to the beneficiary are tax-free so long as they are paid directly to care providers.[272] In his November 1995 Budget Statement, the Chancellor announced that benefits from a range of insurance policies would no longer be taxed.[273] This move was intended to give more flexibility to people in how they use the benefits from their insurance policies. **PPP Lifetime Care plc told us that "we do not accept the need for further tax incentives for what is already a tax efficient product".[274] We endorse this conclusion.**

186. Mr Philip Booth of City University has recently suggested that a better approach to the long-term funding issues would be to introduce a tax allowance for those people who take on responsibility for making some provision for their own care.[275] This would have the effect of reducing current tax revenues whilst reducing future expenditure on long-term care services (though only to the extent to which the people who have taken advantage of the tax allowance would previously have been funded by the State). **The implication of this proposal is that it would allow some people to avoid the current obligation for those who make private health provision to pay doubly, i.e. for public health care through general taxation as well as for their own private provision. For this reason we do not favour the proposal.**

Schemes Founded on General Taxation or Social Insurance

187. During the course of our inquiry we visited the Federal Republic of Germany. In April 1994 a new Statutory Long-Term Care Insurance Scheme was adopted in that country. This constitutes the fifth and last pillar of Germany's Social Insurance System, which can trace its roots back to the statutory health insurance introduced by Reich Chancellor Bismarck in 1883 (succeeded by statutory accident insurance in 1884, disability and old-age pension

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[272] Ev. p2.

[273] *Official Report*, 28 November 1995, cc1067-68.

[274] Ibid.

[275] *Long-term care for the elderly: a review of policy options*, Philip M Booth, Department of Actuarial Science and Statistics, City University, 1996.

insurance in 1889 and unemployment insurance in 1927). The new scheme is financed on a pay-as-you-go approach, the contributions being equally shared between the insured person and his or her employer. Initially the contribution was set at 1% of earnings, rising to 1.7% in July 1996. Employers have received partial compensation for their extra costs through the abolition of a statutory bank holiday.[276] Approximately 92% of the population, already insured under the statutory health insurance scheme, will be insured under the social long-term care insurance scheme; the remaining 8% of the population, who are already insured with private health insurers, will be required to take out private long-term care insurance. Thus both forms of insurance, 'social' and private, are compulsory.[277]

188. The long-term insurance is designed to provide support for the cost of care in a number of circumstances, for example during a period of convalescence following hospitalisation and for accident victims as well as for the elderly. From April 1995, benefits have been available to support the cost of care in an individual's home. The second stage of the scheme, due to come into effect later in 1996, will provide support for the cost of in-patient care in homes and other establishments. The long-term care insurance fund is administered by the health insurance funds, thereby avoiding the need to set up a separate administrative structure. Applicants for benefits from the fund undergo a medical examination to assess whether they need assistance and if so under which of three activities of need. Support may take the form of benefits in kind (i.e. care provided by a specialist care assistant) or Care Benefit (Pflegegeld) paid to the person in need of care, who may then use it to purchase his or her own care arrangements. Benefits in kind are provided at a higher financial level than Care Benefit. The insurance will cover the cost of nursing-home care, if this is needed, up to a level of DM2,800 per month (£1,243 at the current exchange rate),[278] or DM3,300 per month (£1,465) in particularly difficult cases. The individual is responsible for meeting the costs of accommodation and food; in cases where he or she cannot meet these costs, an application can be made for social assistance (Sozialhilfe).

189. The new long-term care insurance system is designed, like other aspects of the German welfare system, to command a high degree of consensual support within society, and to function as a manifestation of social cohesion. However, the German welfare system as a whole has been coming under increasing strain as a result of rising costs, and there is unease among employers about the financial burden that the new long-term care arrangements will impose on them. It is possible that changes in other parts of the welfare state — for example, reductions in employment benefits and changes in pensions — may be made to reduce the overall burden on employers.

190. While the UK does not have the same social insurance systems for providing care, in effect German social insurance impacts much like taxation. A number of organisations felt that funding by means of general taxation was the most fair way to share the risks and burden of long-term care insurance equally across the population.[279] The Medical Practitioners' Union argued that "general taxation is the most efficient way to achieve collective expenditure on matters which benefit the entire population and which are wanted by a substantial majority of the population".[280]

The Respective Merits of Pay-As-You-Go and Funded Schemes

191. State expenditure on long-term care in the UK is currently funded on a pay-as-you-go basis. Pay-as-you-go schemes in general were criticised by many of our witnesses on the grounds that the changing demographic profile, and particularly the changes in the dependency

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[276] Ev. pp89-90.

[277] State Secretary Karl Jung, *Statutory Long-Term Care Insurance in the Federal Republic of Germany: Principal Features and Essential Contents*, Federal Ministry of Labour and Social Affairs, Bonn (1995).

[278] £1 = DM 2.252, as at 22.7.96.

[279] Ev. pp142, 349.

[280] Ev. p327.

ratios, would mean that such schemes would ultimately become too expensive for the country as a whole to afford. They therefore preferred funded schemes involving insurance or pensions.[281]

192. In Section IV we outlined the latest population projections available. We noted that these showed that there is no immediate crisis caused by changes in the overall dependency ratio, which will remain broadly the same until well into the next century.

193. Any change to a funded option is subject to one grave disadvantage. It would involve one generation paying twice over, both for itself in years to come via the funded scheme, and for the current generation of elderly people through taxation. **Such a change would therefore need to take place over a very long time scale in order to be affordable to individuals in the 'change generation'.**

194. The Government's consultation paper notes that some commentators have suggested that a compulsory scheme will be necessary to ensure that people save enough for care in old age.[282] Some of our witnesses likewise argued for the introduction of a compulsory insurance scheme.[283] The Government's argument is that people will wish to choose between different ways of meeting their obligations and Ministers therefore "have no intention of requiring people to take out specific financial products for their own long-term care needs".[284]

195. The National Association of Pension Funds, while not advocating the immediate introduction of a compulsory funded insurance scheme, believed that this would need to happen eventually because "in the end contributions [towards pre-funded insurance will] prove insufficient to get sufficient young people to start saving."[285]

VII — CONCLUSIONS

196. **In this report we have discussed the issues which will underlie future decision-making about the provision and funding of long-term care. We have pointed out examples of good practice in the provision of such care, and have emphasised the need to expand the scope and quality of domiciliary, rehabilitative and respite care; this would benefit the individuals concerned *and* be likely to be cost-effective from the viewpoint of funding authorities. We have called for greater attention to be paid to the need to improve housing facilities for the elderly disabled, and for more effective liaison between housing, social services and health authorities. We have considered the projections currently available as to the future costs of long-term care, and concluded that there is no imminent crisis of affordability. We also express scepticism about the assumptions on which some of the gloomier predictions of escalating costs in the longer term are based. We make clear that the status quo of funding long-term care mainly from general taxation is a defensible option, which is both possible and affordable, but go on to discuss the pros and cons of possible alternative approaches. We call for the long-term care insurance market to be properly regulated. We state that until such time as the Government divulges its own estimates of the likely cost of each option — including the likely costs of its preferred option of partnership schemes — it will not be possible to reach a final decision on the best way forward. Decisions on whether long-term care should be funded through general taxation or through insurance, and if the latter whether the system should be voluntary or compulsory, touch upon fundamental questions concerning the future of the Welfare State, and cannot be tackled in relation to long-term care in isolation.**

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[281] Ev. p323.

[282] Cm 3242, paragraph 2.3.

[283] See, for example, Q480.

[284] Cm 3242, paragraph 2.3.

[285] Q552.

197. It is clear that there is no immediate funding crisis facing the nation in respect of long-term care. There is a window of opportunity within which the national debate on this subject can proceed during the remaining years of this century and beyond. We believe that there is an urgent need to establish a much better knowledge base on the costs and benefits of health promotion, rehabilitation, and preventative social care, on the impact of future demographic, medical and social developments on long-term care costs, and on the costs to the public purse of alternative funding options. Public awareness of the issues and choices involved must be improved, and we hope our report will be a contribution to that process. It is highly desirable that any major changes to current arrangements should be agreed on a basis of all-party consensus in order to provide the stable and certain background for individuals to take effective decisions about their future care.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

1. There has been considerable media and public speculation about the 'crisis' the country supposedly faces in paying for long-term care in the future. We believe that much of this speculation has been founded on unsound evidence, or indeed been downright alarmist, and that the problems the country faces in relation to paying for long-term care, although real, are more manageable than many recent commentators have suggested. (para 9)

2. In our First Report we drew attention to the difficulties which have arisen when home charges exceed the preserved rights figure. We recommended that "the DoH seek evidence from all local authorities as to the current scale of the problem... and in consort with the DSS, conduct a review of the existing arrangements... with the aim of ensuring that no elderly residents should face eviction in the future." In response the DoH stated that "local authorities and the DoH are not in direct contact with the majority who have preserved rights... as they remain the responsibility of the DSS." We are very disappointed with the Government's response, which attempts to shuffle off responsibility and does nothing to meet the needs of some of the most vulnerable members of society. We repeat our recommendation that the DoH, in conjunction with the DSS, should review the situation. (para 20)

3. There is a clear trend towards the provision of high-intensity homecare services, both in terms of the numbers of contact hours provided and in the numbers of visits made. While we welcome the development of packages of care which allow more people with high levels of dependency to be cared for in their own home, if they so wish, we would not expect local authorities, health authorities and housing agencies to lose sight of the fact that preventative services can play an important role in delaying, or reducing, the demand for long-term care in some cases. It is potentially counterproductive for authorities not to invest in preventative services, as this may only lead to the earlier onset of the demand for long-term care, often at a 'crisis point' in the life of an individual needing care. (para 37)

4. It is particularly important that the full value of a properly arranged home-help service is understood. There are merits in such a service whether or not it serves to delay the need for institutional long-term care. There are many people who may benefit, in terms of continuing to live independently in their own home, from relatively low levels of domiciliary services, such as cleaning and other basic housekeeping services. We are concerned by Professor Tinker's evidence suggesting that basic cleaning services are often now unavailable. For an old or disabled person, help in cleaning the house is often at least as important as help with shopping, both because it assuages the mental anxiety and loss of self-esteem that may follow from inability to keep a house clean, and because it is easier to ask neighbours or relatives to go on shopping errands than it is to ask them to undertake basic cleaning tasks. We believe that local authorities should ensure that they take account of the wishes of service users as to the type of services that are arranged on their behalf. (para 38)

5. We are convinced that care services such as those available through the Belfast Intensive Homecare Scheme could be successfully provided on a wide scale in England. (para 43)

6. We endorse the objectives of the Community Care reforms, those of promoting personal choice wherever possible and enabling people to live independently in the community. We have noted the great value to many elderly and disabled people, both in preventative and other terms, of relatively low-intensity domiciliary services, such as cleaning. We also welcome the extension of opportunity for people with higher levels of dependency to be looked after in their own homes, if this is their wish. There will, of course, always have to be a judgement made as to what is the level of cost above which domiciliary care packages cease to be realistically affordable, bearing in mind the equally valid needs of other people in the wider community. The question of where to locate this cut-off point is a difficult one, and we can understand why the Government has decided that it is a matter best left to local discretion. Our own view is that a cut-off point at about the cost of a nursing-care place is

not unreasonable, if treated as a guideline; and we note the success of the Belfast Intensive Homecare Scheme in providing a high level of service within this cost constraint. We do, however, believe that there should be local discretion to exceed this limit in circumstances deemed to be exceptional. The wishes of service users should be taken fully into account in any decisions over the level of domiciliary care to be provided: for instance, some people may *prefer* to receive care in a communal setting due to the greater opportunities for social interaction that such a setting can provide. (para 44)

7. It is crucially important that the charging system should not contain perverse incentives for local authorities to steer individuals towards residential rather than domiciliary care (or indeed, for that matter, for individuals to opt for homecare on financial grounds if this is not in their own best interests). (para 46)

8. Evidence taken in the second phase of our inquiry further supports our view that a shift in thinking towards rehabilitative solutions is desirable. We wholly agree with the ADSS that the recent public debate about the future of long-term care has placed too much emphasis on institutional solutions and has downplayed the potential of rehabilitative services. We repeat the call we made in our earlier report for the NHS to place greater emphasis on rehabilitation, domiciliary and health promotion services. It is perhaps not unreasonable that in the three years following local authorities' assumption of additional responsibilities in April 1993, they should have directed most of their managerial effort at the commissioning and purchasing of residential and nursing-home places. Henceforward, however, they should show more flexibility in their provision of care packages, and we recommend that the DoH should take steps to encourage them to do so. In particular, we believe that all local authorities should be asked to give serious consideration to the setting up of social rehabilitation schemes along the lines of those to which the SSI has drawn attention. We believe that authorities should seek to purchase an increasing number of short-term rehabilitative services and respite care services from local care providers, both public and private. We also believe that necessary measures should be taken to preserve people's rights of access to their own home for a reasonable time after entering care. (paras 49 and 55)

9. We agree with those of our witnesses who felt that housing services are often a neglected part of the community care framework. Housing improvements can offer a happy conjunction of cost-effectiveness for the providing authorities with improved quality of life for those who inhabit the housing. The DoH, in conjunction with the DoE, should take vigorous steps to ensure that housing services fully exploit their potential they have for contributing to the Government's community care objectives, particularly with regard to the development of very sheltered housing schemes and ensuring that ordinary sheltered housing schemes are attractive to the current and future generations of users. The DoH and the DoE should encourage the wider development of collaborative schemes such as community alarm schemes like that operated in Fife and elsewhere. The benefits to be obtained from these and other improvements in housing provision should be taken fully into account as an integral part of future care plans at both local and national level. (para 63)

10. The DoH expresses concern that some health authorities have proposed eligibility criteria which could operate over-restrictively. We share that concern, and look to the DoH to ensure, through their ongoing review and monitoring programme, that this does not happen. We look forward to receiving regular future reports from the DoH on the implementation of the policy. With regard to other areas of interaction between agencies, we have expressed above our belief that schemes similar to the Intensive Homecare Scheme in Belfast *could* operate successfully in England. Nonetheless, the existence of separate authorities responsible for separate functions does, at the least, act as a disincentive to such initiatives and to the seamless provision of services. Whether there is a case for unitary authorities in England along the lines of those in Northern Ireland is too large an issue to be encompassed within the present report, although it is one to which we or our successors in the next Parliament may wish to return. (para 66)

11. In our previous report we commented in some detail on the implications of allowing health authorities to set local criteria for eligibility to receive free, NHS-funded, long-term care. We argued that these local criteria might create inequity, with individuals in some parts of the country receiving free NHS care whilst others in identical circumstances elsewhere had to contribute towards the cost of care commissioned by local authorities. While recognising that the DoH's recent guidance represented a step in the right direction, we called for the national framework to include *national* eligibility criteria "to define what the NHS, as a national service, will always provide". We are still of this view. (para 68)

12. It must be a matter of concern that many members of the public believe that there has been a deliberate change in the rules governing payment for long-term care. In relation to residential care, the former Parliamentary Under-Secretary of State, Mr Bowis, told us that this is not actually the case. Whether it can fairly be said that the rules regarding payment for nursing home care have not altered is more open to question: as we commented in our earlier report, many people who are now cared for in nursing homes on a means-tested basis would in previous decades have been cared for by the NHS without charge. (para 78)

13. While we accept that the desire to pass on an inheritance is an understandable one, it can also be argued that one of the purposes of saving is to save for one's retirement and for unpredictable events. For that reason there is a strong argument that the State should take savings, as well as income, into account when assessing the contribution that individuals should make towards the cost of the residential and domiciliary care services arranged by local authorities, which have always been subject to a means test. Indeed, those individuals' fellow tax-payers might feel justifiably aggrieved if this was not the case. However the situation is complicated by the fact that for many people the majority of their saved wealth takes the form of a housing asset, and although strictly speaking this is no different from any other form of asset, in psychological terms it *is* different: people think of the house they live in as their home, rather than as an asset in the same way that savings are assets. The fear of losing one's home is compounded by the present difficulty of making use of *part* of the wealth represented by a housing asset: this an area where equity release schemes may represent the way forward. (para 79)

14. In our view it is neither equitable nor desirable to create a system which guarantees that *all* assets will be safeguarded for inheritors in *all* circumstances. Nonetheless, policy-makers need to take account of the way patterns of provision, demands upon the State, and public expectations have altered in recent years, and of the widespread perception that the present arrangements for funding long-term care are unfair. (para 80)

15. Given the concerns expressed by many of our witnesses over the lack of robust data regarding the situation in the UK, we recommend that the DoH should ensure that further research on the health status of elderly people and the relationship between longevity and morbidity, taking into account the possible impact of healthier lifestyles, is commissioned and adequately funded. (para 97)

16. Population forecasts through to the middle years of the next century are in themselves relatively reliable. Unfortunately, the level of future demand for long-term care is dependent not only on the size of the elderly population but also, and crucially, on much more unpredictable factors such as the number of people living alone and the health status of the elderly. The latter itself depends on developments which cannot be foreseen such as the extent of medical progress and the degree to which healthier lifestyles are adopted. All attempts to calculate future demand towards the end of the lifetimes of those who are now young therefore contain an element of crystal ball gazing. A number of witnesses, including the former Parliamentary Under-Secretary, Mr Bowis, referred, using a statisticians' term, to an 'expanding funnel of doubt' when projecting so far into the future. One thing clearly emerges from our evidence. This is that the demographic and dependency ratio trends do not bear out suggestions that major problems are looming in the short to medium term, by which we mean the period through to about 2020. After this period the trends may present more of a challenge. (para 98)

17. It is extremely difficult to make reliable projections of the future costs of long-term care over a period of 30 to 40 years, owing to the large number of variables that must be considered and a lack of evidence as to which way trends are moving for some key variables, such as the future incidence of disability amongst the current generation of middle-aged people. (para 99)

18. We discuss some recent projections of the future costs of long-term care, in the interests of giving a full picture of recent public debate. We do not endorse any of the projections, and indeed we are very sceptical about some of them, particularly those which combine in what we think is a confusing way the *actual* costs of long-term care incurred by the State and by individuals, and the *imputed* costs of providing informal care (itself valued in these projections at £7 an hour, which is arguably too high a rate). (Para 100)

19. The overall conclusion drawn by the DoH is that "on almost every scenario ... the absolute demand for long-term care is likely to rise steadily over the period, as is the real cost". This will *not*, however, in the view of the DoH, necessarily lead to long-term care becoming unaffordable. Although the projections spanned a wide range of possibilities, almost all of the outcomes imply future rates of increase which are lower than those accommodated over the past 15 years. They do not support claims that we face a 'demographic timebomb', or at least not one that is likely to explode over the next two to three decades. (paras 113, 114 and 116)

20. We are concerned at the lack of good information on likely changes in the health status of elderly people, and we feel that there is also scope for more research as to what impact improvements in preventative and rehabilitation services could have in alleviating some of the additional demand for long-term care that will inevitably occur as the population ages. We recommend that the DoH commission research on both these areas. (para 117)

21. It is clear from the evidence presented to us that there is highly unlikely to be a dramatic surge in the numbers of elderly people needing long-term care in the period up till 2020. The DoH's central projections indicate that the costs to the taxpayer of providing long-term care services are affordable up until 2031 (the furthest point to which DoH projections have been taken). Many unofficial estimates showing spiralling future costs rest on estimates of the 'costs' of informal care which are unverifiable, probably inflated, and in any case only relevant in relation to that element of care, of unknown extent, which is now provided informally but in future may have to be provided formally. (para 119)

22. However, the demographic trends in the middle decades of the next century indicate that there may be significant increases in costs in that period. Possible options for minimising these costs include improvements in preventative and rehabilitation services, although as we have already pointed out there is a lack of hard evidence about the cost-effectiveness of such approaches. We do have an extended window of opportunity within which plans for dealing with this eventuality can be drawn up. (para 120)

23. The question which remains to be addressed is whether it is necessary in the comparatively short term, let us say during the period of the next Parliament or its successor, to undertake radical changes to the present system of financing long-term care. We received much evidence from those urging such changes. A general point about our adopted approach should be made. Although we deal at some length with the pros and cons of alternative funding options, we are very much aware that a major option in its own right is to maintain the status quo, and continue with the current system whereby general taxation is used to provide NHS care free at the point of delivery and social care subject to a means test. In order fairly to represent the evidence submitted to us we will discuss in detail the various alternative funding options, but this should not be taken as indicating an assumption on our part that the status quo must be unsustainable and that the only argument is about what should replace it. No such assumption has been made. (para 121)

24. We believe that any changes to present models of care and methods of financing long-term care should conform to the following key principles.

- Principle 1: Any changes should maximise independence, self-respect and choice for the individual.
- Principle 2: Any changes should be understandable and perceived as equitable.
- Principle 3: Any changes should improve the way in which long-term care is planned, organised and purchased by multidisciplinary knowledged-based agencies.
- Principle 4: Any changes should provide better support and encouragement to informal carers both in terms of practical help (e.g. training, respite care) and financial help.
- Principle 5: Any changes should include mechanisms to ensure that an efficient and high quality service is provided in all care settings.
- Principle 6: Any changes should be affordable.
- Principle 7: Any new programme of public expenditure on long-term care should, in the case of services provided or paid for by the NHS, as now be available equally to all citizens according to their assessed need for care; and, in the case of means-tested social care services, be designed to meet necessary care need for citizens who have insufficient income or capital to pay for such care from their own resources. (paras 125 to 131)

25. We ... recommend that the concept of NHS nursing homes (or NHS-provided places) should be maintained and they should be provided when possible. (para 135)

26. Of these various proposals, we believe that the RCN suggestion that the nursing costs of long-term care should be the responsibility of the NHS is the most immediately attractive in terms of equity. It has the merit that it would tackle the most manifest unfairness of the present system, the way 'health care' is currently defined to exclude 'nursing care in nursing homes'. Many members of the public quite understandably find this definition baffling. It is clearly illogical and indefensible that whereas someone who is ill in a hospital acute ward receives free nursing care, another person with similar medical problems who is cared for in a nursing home is means-tested for their nursing care. As the RCN point out, this means that "the physical location, rather than the individual's needs, determines whether or not the NHS pays for care". Given that the majority of people in nursing homes are elderly, the effect of the present system is to discriminate on grounds of age. However, the costing of this option is problematic. In putting forward its estimate that implementing the option in England would cost the taxpayer an extra £180 million per annum, the Government emphasises that this calculation is "based on current patterns of care and make[s] no allowance for possible increases in take-up of places nor any effect of increases in fees if there is a large demand effect". We recommend further early examination of and consultation on this proposal. (para 138)

27. One difficulty in assessing the relative merits of the options which have been canvassed before us is that it is not yet possible to compare their estimated costs to the public purse with those of partnership schemes, the Government's own preferred option for tackling the problems of long-term care funding. We asked the Government to supply us with their current best estimate of the cost of the various partnership options proposed in their discussion document, but received a reply that "it would not be meaningful to produce an estimate until the points made in responses to the consultation paper have been studied and details of the scheme have been settled". Later in this report we express our concern that the Government has issued a discussion paper on partnership schemes without producing a range of estimates of the public expenditure implications of this policy option. (para 139)

28. The present low uptake of long-term care insurance makes it difficult to judge its potential for future expansion. Such insurance is at present too expensive for more than a small minority of the population to contemplate: PPP Lifetime Care plc described their client profile as people belonging to socio-economic groups AB, frequently retired from professional or vocational occupations, usually owning their home outright and often possessing an asset base of around £250,000. Witnesses from the ABI told us that this probably represents the upper end of the market, and that some companies offered less ambitious but more affordable policies; nonetheless, the fact remains that such policies are out of reach of the pockets of most people. Even an expansion of the number of policy-holders will not in itself lead to lower premiums. (para 151)

29. We believe that it is essential that the long-term care insurance market is subject to formal regulation, either through the Financial Services Act 1986 or by some other means. This may cause problems of definition, in that it will be necessary to define long-term care insurance so as to distinguish it from medical insurance, but we consider that such problems can be overcome. The need for regulation rests partly on the sheer size of financial commitment for the individual arising from this form of insurance. We also note the views of witnesses from the insurance industry itself, who consider that long-term care insurance will not 'take off' commercially until the public is reassured that they are protected against the kind of unscrupulous practices which took place some years ago in respect of the selling of personal pension plans. We were told that there is, ominously, "already evidence that the sale of long-term care is attracting individuals and companies who see the lack of regulation as attractive". For these reasons we strongly recommend that the Government takes the necessary steps to set up an *enforceable* system of regulation to ensure that individuals are protected against unscrupulous practice and that they can be reassured that insurance packages offered will be appropriate to their needs and financial circumstances. (para 152)

30. We asked the DoH to provide further examples of illustrative costs. ... In response the DoH told us that "it is not for the Government to say how much insurance under a partnership scheme might cost any particular individual ... The examples in the consulation paper were intended to illustrate how the partnership scheme might work in practice, not to provide a definitive guide to costs ...". It is difficult to regard this as a reasonable response to our request. We did not ask for "a definitive guide to costs", but for precisely the same kind of "examples ... intended to illustrate how the partnership scheme might work in practice" that the Government had already provided in detail in their consultation paper. (paras 164 to 166)

31. We received a similar answer in response to a request that the DoH provide us with their current best estimates of the cost to the taxpayer of the various partnership options proposed. ... Once again, we cannot regard this as a satisfactory response to our request. Given that eight months have now passed since the Chancellor of the Exchequer announced the Government's interest in partnership schemes, we would regard it as astonishing if the Treasury and the DoH have not worked out a likely range of costs under the different variables which may be applicable. Given also that the Government has stated its wish to consult on the options it proposes and to initiate a national debate, we see no reason why these rough estimates should not be made public. It is ironic that the Government *has* been prepared to give us its estimate of the cost of the RCN's proposal that the nursing-care element of long-term care should be an NHS responsibility, which is not Government policy, but is not prepared to supply their provisional costings of a proposal which they have announced to Parliament as likely to be adopted. (paras 170-71)

32. In our view partnership schemes may be beneficial for some people: *how* beneficial, and *to whom*, will depend on a range of decisions to be taken by Government and by insurance companies. It is important to recognise that the primary purpose of partnership schemes is asset protection rather than long-term care insurance as such. For the foreseeable future many people will be either too poor to be able to afford such schemes, or too lacking in assets to need them. Equally there will be people whose assets are so substantial that to safeguard them by means of a partnership scheme would require over-insurance, a costly

option just to get access to State-funded care at some stage in the future. We would be worried by any suggestion that partnership schemes are 'the answer' to the problems of long-term care funding. At best they may form a useful part of an overall package that may include other mechanisms such as equity release schemes, which we discuss later in this report. Experience of partnership schemes in the United States is at too early a stage for meaningful lessons to be drawn for the UK. The overall cost to the taxpayer will be a critical consideration, as only when this is known, or can reasonably be estimated, will it be possible to assess whether partnership schemes offer a greater degree of public benefit than some of the other proposals discussed in this report. We deprecate the Government's failure to provide even rough-and-ready costings of its various options. Until such costings are provided, the taxpayer is in effect being invited to sign a blank cheque. (para 172)

33. We accept that pensions are not likely to prove a suitable vehicle for the funding of long-term care, and that the two categories of pensions and long-term care insurance should be kept separate. This is not to say that a system whereby people pay contributions into a separate fund to cover their long-term care at the same time and in the same way as they make pension contributions might not have practical attractions, depending on what overall system for funding long-term care is chosen. The automatic and regular deduction of small amounts of income, as in taxation, is a relatively painless way of making financial provision, and might be particularly suitable as a means of providing long-term care cover for the younger generations, those under 50. In addition, it is, of course, possible under current arrangements for an individual to take a reduced pension, and a lump sum which could be used to purchase a dedicated long-term care insurance policy. (para 179)

34. The specific suggestion that pensioners should be allowed to opt for a smaller initial pension in return for a larger pension later on, which would be used to fund the costs of long-term care, seems to us to be flawed. ... It is clear that the variable pension option does not offer a convincing solution to the problem of fully funding long-term care costs, at any rate for other than a minority of rich people. (para 180)

35. In our view improved equity-release schemes may have a useful part to play in enabling asset-rich but income-poor people to make provision for their long-term care whilst also protecting a proportion of their assets. They would introduce a flexibility which is lacking in current arrangements. Such schemes would be attractive if they allowed, for instance — to take an example we consider realistic — a couple owning an average-value house to purchase long-term care insurance with a three-year benefit period for about one-fifth of the value of the house. In other words, giving up one-fifth of the value of the house now would protect the remaining four-fifths if this happened in conjuction with a partnership scheme. (para 183)

36. However, in view of past experience, it is essential that such equity-release schemes should be properly regulated, as part of the wider system of regulation of long-term care insurance we recommend. The regulation must ensure that schemes fulfil, as a minimum, the following criteria:

- the individual concerned should have an absolute right to remain in his or her home for as long as he or she wishes to;
- he or she should have an absolute right to move house, subject to the equity release provider not suffering financially, if this is what he or she wants to do;
- he or she should know in advance the maximum amount, in cash terms or percentage of house value, that the arrangement will cost him or her; and
- he or she should know in advance which, if any, factors may influence the amount involved, and their relative importance. (para 184)

37. Another alternative approach ... would be to allow tax relief on the insurance premiums paid. ... PPP Lifetime Care plc told us that "we do not accept the need for further tax incentives for what is already a tax efficient product". We endorse this conclusion. (para 185)

38. The implication of the proposal to introduce a tax allowance for people who take on responsibility for making some provision for their own care is that it would allow them to avoid the current obligation for those who make private health provision to pay doubly, i.e. for public health care through general taxation as well as for their own private provision. For this reason we do not favour the proposal. (para 186)

39. Any change to a funded option is subject to one grave disadvantage. It would involve one generation paying twice over, both for itself in years to come via the funded scheme, and for the current generation of elderly people through taxation. Such a change would therefore need to take place over a very long time scale in order to be affordable to individuals in the 'change generation'. (para 193)

40. In this report we have discussed the issues which will underlie future decision-making about the provision and funding of long-term care. We have pointed out examples of good practice in the provision of such care, and have emphasised the need to expand the scope and quality of domiciliary, rehabilitative and respite care; this would benefit the individuals concerned *and* be likely to be cost-effective from the viewpoint of funding authorities. We have called for greater attention to be paid to the need to improve housing facilities for the elderly disabled, and for more effective liaison between housing, social services and health authorities. We have considered the projections currently available as to the future costs of long-term care, and concluded that there is no imminent crisis of affordability. We also express scepticism about the assumptions on which some of the gloomier predictions of escalating costs in the longer term are based. We make clear that the status quo of funding long-term care mainly from general taxation is a defensible option, which is both possible and affordable, but go on to discuss the pros and cons of possible alternative approaches. We call for the long-term care insurance market to be properly regulated. We state that until such time as the Government divulges its own estimates of the likely cost of each option — including the likely costs of its preferred option of partnership schemes — it will not be possible to reach a final decision on the best way forward. Decisions on whether long-term care should be funded through general taxation or through insurance, and if the latter whether the system should be voluntary or compulsory, touch upon fundamental questions concerning the future of the Welfare State, and cannot be tackled in relation to long-term care in isolation. (para 196)

41. It is clear that there is no immediate funding crisis facing the nation in respect of long-term care. There is a window of opportunity within which the national debate on this subject can proceed during the remaining years of this century and beyond. We believe that there is an urgent need to establish a much better knowledge base on the costs and benefits of health promotion, rehabilitation, and preventative social care, on the impact of future demographic, medical and social developments on long-term care costs, and on the costs to the public purse of alternative funding options. Public awareness of the issues and choices involved must be improved, and we hope our report will be a contribution to that process. It is highly desirable that any major changes to current arrangements should be agreed on a basis of all-party consensus in order to provide the stable and certain background for individuals to take effective decisions about their future care. (para 197)

MINUTES OF PROCEEDINGS RELATING TO THE REPORT

Thursday 25 July 1996

Members present:

Mrs Marion Roe, in the Chair

Mr John Austin-Walker	Mr John Marshall
Mr Hugh Bayley	Sir Roger Sims
Mr David Congdon	Rev Martin Smyth
Alice Mahon	Mr John Whittingdale
Lady Olga Maitland	Audrey Wise

The Committee deliberated.

Draft Report, proposed by the Chairman (Long-Term Care: Future Provision and Funding), brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 130 read and agreed to.

A paragraph — (*Mr Hugh Bayley*) — brought up, and read.

Question put, that the paragraph be read a second time.

The Committee divided.

Ayes, 5	Noes, 4
Mr John Austin-Walker	Mr David Congdon
Mr Hugh Bayley	Lady Olga Maitland
Alice Mahon	Sir Roger Sims
Mr John Marshall	Mr John Whittingdale
Audrey Wise	

Paragraph inserted.

Paragraphs 131 (now paragraph 132) to 170 (now paragraph 171) read and agreed to.

Paragraph 171 (now paragraph 172) read, as follows:

"In our view partnership schemes may be beneficial for some people: *how* beneficial, and *to whom*, will depend on a range of decisions to be taken by Government and by insurance companies. It is important to recognise that the primary purpose of partnership schemes is asset protection rather than long-term care insurance as such. For the foreseeable future many people will either be too poor to be able to afford such schemes, or too lacking in assets to need them. Equally there will be people whose assets are so substantial that to safeguard them by means of a partnership scheme would require over-insurance, a costly option just to get access to State-funded care at some stage in the future. We would be worried by any suggestion that partnership schemes are 'the answer' to the problems of long-term care funding. At best they may form a useful part of an overall package that may include other mechanisms such as equity release schemes, which we discuss later in this report. Experience of partnership schemes in the United States is at too early a stage for meaningful lessons to be drawn for the UK. The overall cost to the taxpayer will be a critical consideration, as only when this is known, or can reasonably be estimated, will it be possible to assess whether partnership schemes offer a greater degree of public benefit than some of the other proposals discussed in this report. We deprecate the Government's failure to provide even rough-and-ready costings of its various options. Until such costings are provided, the taxpayer is in effect being invited to sign a blank cheque."

Amendment proposed, in line 13, after the word "UK." to insert the words:

"The US partnership schemes give $1 of capital protection for each $1 of insurance benefit which means they do not require subsidy from public funds. The Government's proposal for £1.50 of capital protection for each £1 of benefit would require public subsidy. We believe that the introduction of partnership insurance, on the US non-subsidised model, would help some elderly people with significant capital assets to pay for long-term care. However, we do not believe that long-term care insurance should be supported by public subsidy because it would be wrong for rich and poor taxpayers alike to have to contribute to what is in effect a welfare benefit for the relatively better-off elderly." — (*Mr Hugh Bayley*.)

Question put, that the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 5
Mr John Austin-Walker	Mr David Congdon
Mr Hugh Bayley	Lady Olga Maitland
Alice Mahon	Mr John Marshall
Audrey Wise	Sir Roger Sims
	Mr John Whittingdale

Paragraph agreed to.

Paragraphs 172 (now paragraph 173) to 196 (now paragraph 197) read and agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Several papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the provisions of Standing Order No.116 (Select committees (reports)) be applied to the Report.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House. — (*The Chairman*.)

Several Memoranda were ordered to be reported to the House.

[Adjourned to a day and time to be fixed by the Chairman.

LIST OF ABBREVIATIONS USED IN THE REPORT

ADLs	Activities of Daily Living
AMA	Association of Metropolitan Authorities
ABI	Association of British Insurers
ACC	Association of County Councils
ADSS	Association of Directors of Social Services
BGS	British Geriatrics Society
DHA	District Health Authority
DoE	Department of the Environment
DoH	Department of Health
DSS	Department of Social Security
FSA	Financial Services Act
GDP	Gross Domestic Product
NAHAT	National Association of Health Authorities and Trusts
NHS	National Health Service
NAPF	National Association of Pension Funds
OPCS	Office of Population Censuses and Surveys
RCN	Royal College of Nursing
SSI	Social Services Inspectorate
VOICES	Voluntary Organisations involved in Caring in the Elderly Sector

LIST OF WITNESSES

LIST OF MEMORANDA INCLUDED IN THE MINUTES OF EVIDENCE

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LIST OF APPENDICES TO THE MINUTES OF EVIDENCE

Published in HC 59-II

UNPUBLISHED MEMORANDA

Additional memoranda have been received from the following and have been reported to the House, but to save printing costs they have not been printed. Copies have been placed in the House of Commons Library where they may be inspected by Members. Other copies are in the Record Office, House of Lords, and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1 (Tel 0171-219 3074). Hours of inspection are from 9.30am to 5.30pm on Mondays to Fridays.

Age Concern [LTC B25]

Alzheimer's Disease Society [LTC B21]

Association of British Insurers [LTC B27]

Association of Charity Officers [LTC B22 & B22A]

Association of Community Health Councils for England & Wales [LTC B29]

Association of County Councils [LTC B8]

Association of Directors of Social Services [LTC B33]

Mr G Andrews [LTC 14A-C & B4 & B4A]

Bacon & Woodrow [LTC B3]

Mr G R Bage, Normanhurst Nursing Home [LTC 82 A&B]

Bradstock Insurance Broking Group [LTC B6]

Carers National Association [LTC B28]

Dr Gillian Craig [LTC 88 & B41]

Mr Douglas Crookes [LTC 116 & 116A]

Bristol and District Community Health Council [LTC 93]

British Association of Social Workers [LTC B44]

British Federation of Care Home Proprietors [LTC B18]

British Geriatrics Society [LTC B11]

British Medical Association [LTC B36]

The British United Provident Association LTd (BUPA) [LTC 73B]

Bury Community Health Council [LTC B1]

Cancer Relief Macmillan Fund [LTC 90]

The College of Speech & Language Therapists [LTC 101]

Mr J P de Courcy Meade [LTC 125]

Crossroads Caring for Carers [LTC B43]

Department of Health [LTC 9X]

District Judge Gordon R Ashton [LTC B16]

East & North Hertfordshire Health Authority and West Hertfordshire Health Authority [LTC 136]

Mr Robert Egerton [LTC 119]

English National Board for Nursing, Midwifery and Health Visiting [LTC 92 & 92A]

The European Commission [LTC 131]

Fife Health Council [LTC 115]

Grampian Healthcare NHS Trust [LTC B9]

Mr John Greenway MP [LTC 122]

Professor J Grimley Evans [LTC B15]

Health Visitors' Association [LTC 100]

Independent Healthcare Association [LTC B32]

International Viatical Settlements (UK) Ltd [LTC 78A]

Dr J M Kellett, St George's Hospital Medical School [LTC 113]

Mrs June Lait [LTC 118]

The Law Society [LTC B35]

Department of Epidemiology and Public Health, University of Leicester [LTC 79 & B5 &B5A]

Lothian Health Council [LTC 107]

Rt Hon John MacGregor MP [LTC 89]

Molnlycke [LTC 128]

Motor and Allied Trades Benevolent Fund [LTC B13]

Mercantile & General Reinsurance [LTC B38]

The Multiple Sclerosis Society [LTC 58A]

National Alliance of the Relatives of the Mentally Ill [LTC 87 & B2]

National Consumer Council [LTC B19]

National Council for Hospice and Specialist Palliative Care Services [LTC 127]

National Institute for Social Work [LTC B37]

National Society for Mentally Handicapped People in Residential Care [LTC 56A]

North Essex Health Authority [LTC 140]

PPP lifetime care plc [LTC B45]

Peter Cockroft Associates [LTC B10]

Psychologists Special Interest Group for the Elderly [LTC B42]

Quality Care & Nursing Home Advice Service [LTC B24]

Mr Timothy Rae-Clarke [LTC 85]

The Relatives Association [LTC B31]

Religious Society of Friends in Britain [LTC B30]

Mr D Rixon [LTC 83]

Royal College of General Practitioners [LTC B40]

Royal College of Nursing [LTC B7]

Royal College of Psychiatrists [LTC B39]

Mrs B Smallwood [LTC 76]

Special Interest Group on Ageing (SIGA) [LTC B34]

Dr Graham Stokes [LTC 104]

Takare plc [LTC 130 A&B]

United Care Associations [LTC B23]

Mr A L Wells [LTC 55A & B20]

Mr R West, West Midlands Residential Homes Association (Birmingham) [LTC 74A & B17]

Mrs Adele Wilkinson [LTC 80 & B12]

Mr Bob Woods [LTC 97]

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